REPORT 3

METROPOLITAN STATE HOSPITAL

August 27-31, 2007

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Metropolitan State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Metropolitan State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Metropolitan State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, M.D.) and four expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; Elizabeth Chura, M.S.R.N.; and Monica Sage, OTR/L) visited Metropolitan State Hospital (MSH) from August 27 to 31, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed baseline assessment of the status of compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

B. Methodology

The evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included but were not limited to charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative and clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows:

Abbreviation	Definition
N	Total target population
n	Target population reviewed
%S	Sample size; target population reviewed (n) divided by total target population (N), multiplied by 100
%C	Compliance rate

Means over time were calculated by adding the compliance rates for the months and dividing by the number of months for which data was provided. For example, if one month of data was missing over a six-month period, the denominator used was five months rather than six. Means (averages) across a set of indicators were calculated by adding the compliance rates for the indicators and dividing by the number of indicators.

MSH appears to have made progress in adhering to the above definitions. However, in a number of instances, the total target populations were not appropriately defined, the mean sample sizes were not calculated and data regarding the target population reviewed were confused with compliance rates. As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored.

D. Findings

This section addresses the following specific areas and processes that are not covered in the body of the compliance report.

1. Key Indicator Data

The key indicator data provided by the facility are graphed and presented in the Appendix. The following observations are made:

a) The key indicator data are an essential ingredient of a culture of performance improvement. While they are provided to the Court Monitor as required by the EP, the primary users of the data should be the clinical and administrative leadership and management of the facility.

b) MSH has now provided 15 months of key indicator data (June 2006 through August 2007). This provides sufficient data to begin identifying patterns and outlier results more reliably.
c) The data provided as of August 2007 suggests positive trends that include:
   i. Acts of self-aggression have declined from a peak of 26 in October 2006 to ten or fewer per month for the past four months.
   ii. Incidents of escape/unauthorized absence have stabilized at a relatively low level following the late 2006 spike.
   iii. While reported medication variances due to prescribing have risen, this is likely a positive development given the Court Monitor's belief that such errors have been consistently underreported. It now appears that more such errors are being captured, which gives rise to opportunities for performance improvement.
   iv. Non-adherence to the WRP is trending down.
   v. The use of PRN medications is showing a consistent downward trend through 2007, and the use of restraint is generally lower as well. (Please see "Trends to be further evaluated and explained" for a related comment.)
d) At the same time, the data reveals patterns that should be noted, investigated and explained by the facility:
   i. The numbers of allegations of abuse, neglect, and/or exploitation are showing reversals of magnitude from period to period. This may be random, or there may be other explanations (e.g. a period with a relative high number of allegations is followed by a period of vigilance, which results in a lower number in the subsequent period and thus to a relaxing of vigilance).
   ii. After trending down in the first four months of 2007, the number of individuals with a body mass index in the overweight to obese range has risen. The fairly stark increase between May and June raises the possibility that this may have resulted from changes in reporting or data collection, but this should be investigated and confirmed.
   iii. The number of individuals diagnosed with fractures spiked to 24 in August from 13 in the prior two months.
   iv. The number of hospitalizations spiked in July 2007 to the highest level since the facility began reporting data. (However, the rehospitalization rate remains fairly consistent.)
   v. The number of individuals diagnosed with seizure disorder has trended consistently upward since data reporting began. Is this due to a change in patient population, better diagnoses, or other factors? Along the same line, the use of phenytoin to treat seizure disorder spiked in July well beyond any previous report.
   vi. The use of Stat medications has trended up at the same time that the use of PRN medications has declined. Is this a genuine increase in the use of Stat medications, or a more precise classification of a medication as Stat rather than PRN, as may have been done in the past?
   vii. Despite the positive development of apparently more effective capture of prescribing variances, the total number of medication variances reported fell by more than 50% between July and August 2007. This is an unusually precipitous decline and should be extensively tested for validity.

e) The issue of instances of data that does not seem to logically "foot" persists. For example, the number of females with a waist circumference greater than 35 inches was 44 in May and rose to 85 in June. The facility also reports that three females had an increase in waist circumference from less than to more than 35 inches in June. By deduction, this means that in June the facility admitted 38 females with waist circumference greater than 35 inches. This is not impossible, but does sound high. The facility should have a process in place to spot outlier results and evaluate to see if they are true statistical anomalies or result from data reporting and collection practices.

2. Monitoring, Mentoring and Self-Evaluation

The facility has assessed its compliance with the EP during this review period using a variety of monitoring tools and other mechanisms. The following observations are noteworthy:

a) The California Department of Mental Health (DMH) has made further progress in streamlining and standardizing monitoring systems across hospitals. In addition, DMH has made substantial progress in developing and implementing statewide monitoring tools in Psychology, Social Work, Discharge Planning, Nutrition, and Infection Control.
b) MSH has continued implementation of the standardized monitoring tools that were developed by the DMH and, in some cases, has taken the initiative of modifying some of the monitoring indicators to improve alignment with requirements of the EP and the clinical meaningfulness of the review process. This initiative and leadership is valuable and should be shared with DMH and other facilities to improve the final versions that will be used statewide.
c) By and large, the section leaders have demonstrated improved knowledge of their data and understanding of the relevance of these data to the purposes of the EP. However, the facility's self-assessment report demonstrates that the leaders have some difficulty providing clear accounts of the facility's progress in response to the specific requirements of the EP and the recommendations of the court monitor. In addition, there continues to be some difficulty in the identification of appropriate populations that are targeted for the review process.
d) MSH has improved the sample sizes during this review period, including a review of up to 100% sample in some areas (e.g. integrated psychiatric assessments). However, more work is needed to ensure at least 20% sample of the appropriate target populations. If the target population is very small (e.g. individuals diagnosed with Tardive Dyskinesia), the total target population should be sampled.
e) The facility has implemented revisions in its procedures as recommended by the court monitor. However, some section leaders/discipline chiefs did not readily identify these revisions nor demonstrate an understanding of the rationale and value of these process changes.
f) MSH has maintained a core of trained staff to collect data using each of the monitoring tools. However, the current staffing shortage and the existing system of reviews by discipline chiefs have resulted in a situation whereby senior clinicians appear

to be more concerned with monitoring than with mentoring of staff. Mentoring is an essential component of monitoring and all senior clinicians must invest needed time and energy to perform this critical function.

g) All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each hospital. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

h) The DMH has yet to ensure that the tools and data collection are automated.

i) The EP requires the facilities to revise and align policies and procedures regarding the Wellness and Recovery model. These policies and procedures should be statewide rather than hospital-specific and in the interest of time, it is recommended that the DMH Consulting Psychologist assume leadership on this task and have the policies revised for statewide adoption and implementation by January 1, 2008.

j) The format by which data are provided by the facilities to the Court Monitor remains unwieldy; it would be helpful to establish a mutually convenient means to provide data from the Plato system.

3. Implementation of the EP

a) Structure of current and planned implementation:

i. MSH has made significant progress in the following areas:

- New structures for delivery of Positive Behavioral Supports, including the functional and structural behavioral assessments;
- New structures for skill-based interventions for bed-bound individuals;
- New formats for admission and integrated nursing assessments;
- New administrative leadership for rehabilitation services;
- Participation by rehabilitation therapists as group leaders on the Mall;
- New system of review of outcome of abuse/neglect investigations by clinical leadership; and
- Newly developed procedures in the reporting of adverse drug reactions and medication variances.

ii. MSH has made some progress in the following areas:

- Process of WRP reviews by the WRPTs;
- The number of medication education groups on the Mall;
- Finalization of psychiatric diagnoses listed as NOS;
- Documentation by nursing of PRN/Stat medication administration;
- New system of time limits in the prescription of PRN/Stat medications; and

- Identification of individuals suffering from involuntary movements.

iii. Overall, MSH has made progress since the last review, but the extent and pace of this progress must be improved and accelerated in order to achieve compliance with the EP within the required time frames that are required by the consent judgment.

iv. At this time, MSH appears to have a cohesive and committed administrative and clinical leadership. Overall, there continues to be evidence of sincere efforts to move the facility along on the spectrum of change towards compliance with the EP. However, during this review period, the facility did not provide sufficient amount and intensity of WRP training (didactic and practical) and there has been a lack of energy and direction in the implementation of the newly developed procedures for reporting of adverse drug reactions and medication variances.

v. The facility appears to have in place most of the foundational processes and structures that are required for implementation of the EP and must now focus its attention on improving the quality of clinical services to its individuals.

vi. The staffing shortages and the current implementation of the matrix model continue to impede the facility's efforts in achieving compliance. However, some of the deficiencies that continue to hamper compliance cannot be explained solely by these factors.

vii. As mentioned in the previous reports, the DMH-approved monitoring system has the potential to demonstrate the effectiveness of the recovery-oriented psychiatric rehabilitation of the individuals served in the DMH forensic hospitals.

viii. Given that the EP provides the basis for mental health services delivered in all state DMH facilities, it is the monitor's recommendation that the DMH seriously consider standardizing Administrative Directives that impact these services across all hospitals.

b) Function of current and planned implementation:

i. MSH has to make further progress in the process and content of Wellness Recovery Planning. Discipline seniors should be trained to not only monitor, but also mentor clinicians in their areas. The WRPTs need to work with dedicated trainers who can provide feedback and teaching on an ongoing basis.

ii. The team meetings attended by the monitor showed some progress in the overall process of the team meetings. However, there continues to be deficiencies in the process and content of WRPs. In general, the deficiencies indicate that the facility has not made sufficient progress in integrating the principles and practice guidance in its WRP Manual into the day-to-day operations of the WRPTs. Section C.1 of this report provides an outline of the areas of progress and the persistent deficiencies that must be corrected to achieve compliance.

iii. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.

iv. MSH has yet to continue and make further progress in implementing a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.

v. A well-functioning PSR mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:

- **Mall hours**: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

Required PSR MALL Hours as Facilitators or Co-Facilitators		
	Admissions Staff	Long-Term Staff
Psychiatry	4	8
Psychology	5	10
SW	5	10
RT	7	15
RN	6	12
PT	6	12
FTE Mall staff	20 hours as mall group facilitator	
Other hospital staff	As determined locally at each hospital	

The Long-Term staff mall hours are specified in the DMH Long Term Care Services Division Strategic Plan FY 2007-2009. The hours have been reduced for the Admissions clinical staff because of the heavy assessment workload and increased number of Wellness and Recovery Planning Conferences (WRPCs) that are held during the first 60 days of admission. There is no reduction in the required 20 hours of mall services provided to the individuals.

It is expected that during fixed mall hours, the Program/Units will be closed and all unit and clinical staff will provide services at the PSR Mall. Each hospital should develop and implement an Administrative Directive regarding the provision of emergency or temporary medical care during mall hours.

- **Progress notes**: None of the monitored facilities has a system that requires providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT), the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no data on which to base the revisions of an individual's objectives and interventions. This is unacceptable and not aligned with the requirements as stated in the DMH WRP Manual. All

hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies no later than October 1, 2007.

- **Cognitive screening for PSR Mall groups**: PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

  The cognitive screening protocol will also provide information for the team psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that no later than January 1, 2008, cognitive screening has been completed for all individuals and that their mall groups are aligned with their cognitive level.
- **PSR Mall, Vocational Services and Central Program Services (CPS)**: The DMH facilities have made some progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that no later than January 1, 2008, there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
- **Virtual PSR Mall**: Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. This service should be available to this group of individuals no later than January 1, 2008.

4. Staffing

The MSH staffing table below shows the staffing pattern at the hospital as of June 30, 2007. These data were provided by the California DMH. The table shows that there continues to be significant shortages of staff in several core clinical disciplines: senior psychiatrists, staff psychologists, senior psychologists, pharmacists, pharmacy technicians, social workers, supervising nurses and rehabilitation therapists. In general, these shortages have persisted since the last review (despite increased allocations by the state for many of these positions). As mentioned in the monitor's previous reports, these shortages can negatively affect service delivery and the safety and security of individuals and staff. The shortages of psychiatrists, psychologists, pharmacists and rehabilitation therapists have had direct negative impact on the facility's compliance with requirements of the EP.

Metropolitan State Hospital Vacancy Totals as of 7/31/2007					
Identified Clinical Positions	**Budgeted Positions 07/08 F.Y.**	**Filled Positions**	**Vacancies**	**Vacancy Rate**	**Comments**
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0%	
Assistant Director of Dietetics	2.00	2.00	0.00	0%	
Audiologist I	0.00	0.00	0.00	0%	Services Contracted Out
Chief Dentist	0.00	0.00	0.00	0%	
Chief Physician & Surgeon	0.00	0.00	0.00	0%	
Chief, Central Program Services	1.00	1.00	0.00	0%	
Chief Psychologist	1.00	1.00	0.00	0%	
Clinical Dietician/Pre-Reg. Clin. Dietician	8.00	8.00	0.00	0%	
Clinical Laboratory Technologist	5.00	4.00	1.00	20%	
Clinical Social Worker	48.30	29.30	19.00	39%	
Coordinator of Nursing Services	1.00	1.00	0.00	0%	
Coordinator of Volunteer Services	1.00	1.00	0.00	0%	
Dental Assistant	2.00	2.00	0.00	0%	
Dental Hygienist	0.00	0.00	0.00	0%	
Dentist	2.00	2.00	0.00	0%	
Dietetic Technician	2.00	2.00	0.00	0%	
E.E.G. Technician	1.00	1.00	0.00	0%	
Food Service Technician	82.00	65.50	16.50	20%	
Hospital Police Lieutenant	2.00	2.00	0.00	0%	
Hospital Police Officer	53.00	52.00	1.00	2%	
Hospital Police Sergeant	6.00	5.00	1.00	17%	
Hospital Worker	6.00	6.00	0.00	0%	

Metropolitan State Hospital Vacancy Totals as of 7/31/2007					
Identified Clinical Positions	**Budgeted Positions 07/08 F.Y.**	**Filled Positions**	**Vacancies**	**Vacancy Rate**	**Comments**
Health Record Technician I	29.00	20.00	9.00	31%	
Health Record Technician II Sp	4.00	3.00	1.00	25%	
Health Record Technician II Sup	3.00	1.00	2.00	67%	
Health Record Technician II Sp	2.00	2.00	0.00	0%	
Health Services Specialist	34.00	29.00	5.00	15%	
Institution Artist Facilitator	1.00	0.00	1.00	100%	
Licensed Vocational Nurse	47.00	44.60	2.40	5%	
Medical Technical Assistant	0.00	0.00	0.00	0%	
Nurse Instructor	4.00	4.00	0.00	0%	
Nurse Practitioner	1.00	1.00	0.00	0%	
Nursing Coordinator	6.00	6.00	0.00	0%	
Office Technician	52.50	36.00	16.50	31%	
Pathologist	0.00	0.00	0.00	0%	Services Contracted Out
Pharmacist I	18.60	14.60	4.00	22%	
Pharmacist II	2.00	2.00	0.00	0%	
Pharmacy Services Manager	1.00	1.00	0.00	0%	
Pharmacy Technician	13.60	10.60	3.00	22%	
Physician & Surgeon	20.70	20.50	0.20	1%	
Podiatrist	1.00	1.00	0.00	0%	
Pre-licensed Pharmacist	0.00	0.00	0.00	0%	
Pre-licensed Psychiatric Technician	6.00	6.00	0.00	0%	
Program Assistant	7.00	6.00	1.00	14%	

Metropolitan State Hospital Vacancy Totals as of 7/31/2007					
Identified Clinical Positions	**Budgeted Positions 07/08 F.Y.**	**Filled Positions**	**Vacancies**	**Vacancy Rate**	**Comments**
Program Consultant (RT, PSW, Psych)	2.00	1.00	1.00	50%	
Program Director	6.00	6.00	0.00	0%	
Psychiatric Nursing Education Director	1.00	1.00	0.00	0%	
Psychiatric Technician	290.00	266.00	24.00	8%	Registry = 14.5 FTE
Psychiatric Technician Trainee	0.00	0.00	0.00	0%	Registry = 4.0 FTE
Psychiatric Technician Assistant	51.00	48.00	3.00	6%	Registry = 4.0 FTE
Psychiatric Technician Instructor	1.00	0.00	1.00	100%	
Psychologist-HF, (Safety)	40.00	23.00	17.00	43%	
Public Health Nurse II/I	2.00	2.00	0.00	0%	
Radiologic Technologist	1.00	1.00	0.00	0%	
Registered Nurse	150.10	144.80	5.30	4%	Registry = 10.17 FTE
Reg. Nurse Pre Registered	0.00	0.00	0.00	0%	
Rehabilitation Therapist	44.50	39.10	5.40	12%	
Special Investigator	1.00	0.00	1.00	100%	
Special Investigator, Senior	3.10	2.00	1.10	35%	
Speech Pathologist I	0.00	0.00	0.00	0%	Services Contracted Out
Sr. Psychiatrist	11.50	6.00	5.50	48%	
Sr. Psychologist (Spvr and Spec)	9.00	0.00	9.00	100%	
Sr. Psych Tech(Safety)	53.00	43.00	10.00	19%	
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0%	
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	0%	
Staff Psychiatrist	43.00	40.85	2.15	5%	

Metropolitan State Hospital Vacancy Totals as of 7/31/2007					
Identified Clinical Positions	**Budgeted Positions 07/08 F.Y.**	**Filled Positions**	**Vacancies**	**Vacancy Rate**	**Comments**
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0%	
Supervising Registered Nurse	9.00	6.00	3.00	33%	
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0%	
Teacher-Adult Educ./Vocational Instructor	7.00	7.00	0.00	0%	
Teaching Assistant	10.00	6.00	4.00	40%	
Unit Supervisor	21.00	15.00	6.00	29%	
Vocational Services Instructor	2.00	1.00	1.00	50%	

Earlier in 2007, the DMH began to lose clinical staff to the Department of Corrections and Rehabilitation (CDCR) due to salary increases that were court-ordered for CDCR clinicians. DMH subsequently took some timely and decisive actions to address the pay differential, which is expected to resolve the crisis, reverse the negative impact on DMH facilities, and continue implementation of the Enhancement Plan. Additionally, DMH has utilized some emergency contracts to fill vital clinical positions. While the Court Monitor believes that the stability of permanent staff is important to sustain performance improvement efforts, it is also acknowledged that the use of contract positions is a critical interim measure that has assisted and will assist the DMH to continue its efforts to improve care and services while continuing to retain current staff and recruit permanent staff with competitive salaries.

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

In order to ensure sufficient Registered Nurses to fulfill the requirements of the Enhancement Plan, the nursing staff skill mix should be 35-40% RNs and 60-65% Psychiatric Technicians and/or LVNs. Additionally, there should be a sufficient number of

nursing educators, supervisors, and administrators, who should not be included in the calculation of NCHPPD, to ensure that generally accepted professional standards of psychiatric mental health nursing care are fully met.

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.

A finding of partial compliance indicates that the facility has taken steps that are oriented toward achieving compliance with a particular requirement of the EP but is not yet achieving results that substantially comply with EP requirements. Additionally, in some instances the Court Monitor has rendered a finding of partial compliance despite monitoring data that would appear to suggest non-compliance. This is because in some cases, the facility uses a monitoring indicator with multiple underlying requirements and an all-or-none scoring protocol. For example, a monitoring indicator may have ten underlying requirements and the facility may meet nine of the requirements, but receive a score of 0% compliance for falling short on one of the ten indicators.

F. Next Steps

1. The Court Monitor's team's schedule for the next six months is as follows:
   a) Atascadero State Hospital: October 15-19, 2007

   b) Patton State Hospital: November 26-30, 2007
   c) Napa State Hospital: January 28 – February 1, 2008
2. The Court Monitor's team is scheduled to reevaluate Metropolitan State Hospital March 10-14, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. MSH has begun implementation of its WRP training curriculum. 2. MSH has made some progress in the process of WRP reviews, including the implementation of reviews according to schedules required by the EP. 3. MSH has made further improvements in the organization and presentation of data to review its progress since the last tour. 4. MSH has implemented its process of tracking individuals who reach triggers of non-adherence to WRPs and responses of the WRPTs to these events. 5. MSH has increased the number of groups providing medication education to individuals, based on needs assessment.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Nady Hanna, MD, President of Medical Staff 2. Michael Barsom, MD, Acting Medical Director 3. Bala Gulasekaram, MD, Chief of Psychiatry Department 4. Kenneth Layman, Treatment Enhancement Coordinator <u>Reviewed</u>: 1. WRP Trainers' Competency Database 2. WRPT Phase II Training Database 3. MSH data regarding percentages of WRPT members who have been trained to competency in WRP

		4. Recommended Sequence of Tasks for WRP 5. Recommended Steps for Engaging Individuals in Their WRPs 6. Case Formulation Worksheet 7. DMH WRP Observation Monitoring Form 8. DMH WRP Observation Monitoring Form Instructions 9. DMH Observation Monitoring summary data (7-day, 14-day, quarterly, monthly and annual meetings), March to July 2007 10. Team Leadership Monitoring (Psychiatrist) Form 11. Team Leadership Monitoring (Psychiatrist) Form summary data March to July 2007 12. Psychiatric Physician Manual, revised 13. Questionnaire on views of WRPT members regarding team leader responsibilities 14. Results of survey of WRPT members regarding team leaders' performance 15. DMH WRP Clinical Chart Auditing Form 16. DMH WRP Clinical Chart Auditing Form Instructions 17. MSH data regarding staff vacancies (reported July 31, 2007) 18. MSH data regarding attendance by core WRPT members, March to July 2007 19. MSH data regarding case loads of WRPT core members (admissions and long-term care units) 20. CET Report summary data (March to July 2007) <u>Observed</u>: 1. WRPC (Program III, unit 409) for monthly review of RD 2. WRPC (Program III, unit 401) for monthly review of JD 3. WRPC (Program II, unit 412) for monthly review of AT
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Implement the revised DMH WRP Manual.

	himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Findings:** MSH has implemented the revised Manual (March 2007). **Recommendation 2, March 2007:** Continue training provided to WRP trainers and documentation of training to competency. **Recommendation 3, March 2007:** Ensure competency-based training of all members of the WRPTs. **Recommendation 4, March 2007:** Ensure that all WRPTs at the facility receive the same level of training. **Findings:** At this time, MSH has four designated WRP trainers. Since the last review, two trainers (a psychologist and a social worker) left the facility. In early April, the facility added one trainer, a rehabilitation therapist, who was trained to competency (as evidenced by WRP Knowledge Assessment scores as well as behavioral demonstration). Review of the training records of core WRPT members (March to July 2007) indicates that 24 hours of training (Phase II) were provided and that 25 members received this training. The training was provided by WRP trainers who had been trained to competency. Of the 25 members trained, 96% met competency-based standards. MSH developed posters that outline steps in the process of WRP and placed these posters in all rooms used for WRPCs. The steps are appropriate, but the presentation of each team's member's assessment of the individual's progress was placed out of sequence. The facility corrected the sequence promptly when this observation was made by the monitor.

		MSH reviewed the training records (Phase II) of all WRPT members from March to July 2007 (average N=166). The facility found that 83% of these members met its competency standard (a score of 80% or more on the WRP Knowledge Assessment based on the eight-hour Phase II training). MSH has yet to implement its plan of providing all teams with dedicated program trainers to provide Phase III training, including ongoing mentoring and feedback. **Recommendation 5, March 2007:** Continue new employee WRP training (for non-nursing disciplines). **Findings:** The WRP Master Trainer/Consultant and WRP Trainers conducted a four-hour training that addressed all identified curriculum areas during new employee orientation weeks (June and July 2007). Records indicate that 13 WRPT members were trained, with 11 (85%) found competent, and that 21 non-CET nursing staff were trained, with 100% meeting the competency standard. **Other findings:** The team meetings attended by the monitor showed some progress in the overall process of the team meetings. The following are examples: 1. All meetings started on time. 2. It was clear that the team psychiatrists were leaders of the process. 3. The teams conducted a discussion of the individual's status prior to inviting the individual, including some review of risk factors. 4. The teams reviewed the individual's attendance at the Mall. 5. The team leaders reviewed the individual's participation in Mall groups that were facilitated by the leaders.

		6. The team members were respectful of the individuals and made a sincere effort to elicit their input. However, the team meetings showed the following deficiencies: 1. There were no parameters for the teams' discussion of the individual's progress prior to the arrival of the individual. The following are examples: a. The teams did not provide an adequate summary of the results of their assessments. b. The discussion did not provide guidance regarding the areas that the teams needed to review with the individual. c. Some discussions involved finalization of the entire WRP prior to the individual's arrival. 2. The updates of the present status were generally incomplete. 3. The review of foci, objectives and interventions were generally not informed by the assessments, the case formulation and the review of progress in Mall groups. 4. The foci did not address all of the individual's needs. 5. Only one meeting resulted in the formulation of objectives and interventions that approached compliance with requirements of the EP. 6. There was no mechanism to review the progress of individuals in Mall groups (except for those groups that were facilitated by members of the WRPT). 7. In general, the teams struggled with the engagement of individuals in the review of objectives and interventions. In general, the above deficiencies indicate that the facility has not made sufficient progress in integrating the principles and practice guidance in its WRP Manual into the day-to-day operations of the WRPTs. There is a strong need for the facility to provide its WRPTs with increased training sessions, including ongoing feedback and

		mentoring by senior clinicians. **Compliance:** Partial. **Current recommendations**: 1. Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs to correct the deficiencies identified above. 2. Increase training sessions provided to WRP trainers (Phases II and III). 3. Provide clear documentation of WRP training sessions provided to the trainers and to the WRPTs. 4. Provide documentation of WRP competencies of WRPTs. 5. Continue new employee WRP training (for non-nursing disciplines).
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to monitor the presence and participation by team leaders in the WRPCs. **Recommendation 2, March 2007:** Standardize the process of monitoring of the presence and participation by team leaders across facilities. **Findings:** MSH used the DMH Observation Monitoring Form to assess its compliance with this requirement of the EP. The facility reviewed an average sample size of 7% from March to July 2007 (N= the total number of WRPs due for the month). The sample included seven-day, 14-day, monthly, quarterly and annual reviews. The facility recognized a possible variance of approximately 3-4% in the calculation of the total

number of WRPs due to lack of automation at this time. The mean compliance rate was 87%.

To assess the participation of the team leaders, the facility used the Psychiatry Team Leadership Monitoring Form (March to July 2007). Senior Psychiatrists conducted two audits per program per month (March to July 2007). The following are the monitoring indicators and corresponding mean compliance rates:

1.	Psychiatrist was present.	100%
2.	Psychiatrist elicited the participation of all disciplines.	89%
3.	Psychiatrist ensured the (integration of) assessments from other disciplines into the case formulation.	82%
4.	Psychiatrist ensured the "Present Status" section in the Case Formulation was updated.	99%
5.	Psychiatrist ensured that the interventions were linked to the measurable objectives.	77%
6.	Psychiatrist ensured the individual participated in the treatment, rehabilitation and enrichment activities which are goal directed, individualized based on a thorough knowledge of the individual's psychosocial history and previous response.	83%

MSH reported that further training is needed to improve compliance regarding the psychiatrists' role in ensuring that interventions were linked to the measurable objectives.

The DMH has yet to standardize the process of monitoring of the presence and participation by team leaders across facilities.

		Recommendation 3, March 2007: The revised Psychiatric Physician Manual should address the leader's responsibility to ensure a sequence of tasks that facilitates WRP as well as proper participation by individuals in the WRP conferences. **Findings:** Section 4.6 of the revised Manual incorporates this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs. (Also applicable to C.1.c through C.1.f). 2. Continue to monitor the presence and participation by team leaders in the WRPCs. 3. Standardize the process of monitoring of the presence and participation by team leaders across facilities.
C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Monitor adequate sample of WRP conferences regarding this requirement. **Findings:** Using the DMH WRP Observation Monitoring Form, MSH reviewed an average sample size of 7% (March to July 2007). The sample size was based on the estimated total number of WRPs due for the month. This represents an improved sample size compared to the last review. The facility anticipates further improvement in the sample size due to the recent hiring of additional two full-time auditors, improved WRP

		schedule posting procedure and manager oversight and development of an action plan to decrease WRP cancellations. **Other findings:** Using the above-mentioned process, MSH assessed its compliance with this requirement of the EP and reported a mean compliance rate of 24%. The facility assessed that factors contributing to low compliance, including for example that some teams are not using the task tracking forms consistently. **Compliance:** Partial. **Current recommendations**: 1. Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs. 2. Monitor this requirement based on at least 20% sample.
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Resume the practice of surveying team members once adequate training has been provided to the team leaders. **Findings:** MSH has implemented this recommendation. Using this survey, the facility found that most team members agreed that psychiatrists assumed this responsibility and that they ensured the provision of competent, necessary and appropriate psychiatric and medical care. The following is an outline of the data (PTs did not participate):

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><th></th><th>MD</th><th>PhD</th><th>SW</th><th>RT</th><th>RN</th><th>OTHER</th></tr>
<tr><td>Strongly agree</td><td>100%</td><td>66.6%</td><td>60%</td><td>75%</td><td>60%</td><td>80%</td></tr>
<tr><td>Agree</td><td>0%</td><td>16.7%</td><td>20%</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Satisfactory</td><td>0%</td><td>0%</td><td>20%</td><td>12.5%</td><td>0%</td><td>0%</td></tr>
<tr><td>Disagree</td><td>0%</td><td>16.7%</td><td>0%</td><td>12.5%</td><td>40%</td><td>20%</td></tr>
<tr><td>Strongly disagree</td><td>0%</td><td>0%</td><td>0%</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

The facility's data regarding other questions on this survey are not relevant to the role of psychiatrists as the team leaders.

Recommendation 2, March 2007:
Implement the DMH WRP Clinical Chart Auditing Form.

Findings:
MSH has implemented this recommendation. Data based on this form are summarized in Section C.2.

Compliance:
Partial.

Current recommendations:
1. Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs.
2. Continue to survey the views of team members regarding the role of psychiatrists as team leaders.
3. Present data from the Clinical Chart Auditing Form regarding this requirement.
</td>
</tr>
<tr>
<td>C.1.e</td>
<td>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Monitor quality of assessments for all disciplines.</td>
</tr>
</table>

	the therapeutic and rehabilitation services.	**Findings:** MSH has yet to implement this recommendation. A statewide process is underway to refine monitoring of the quality of psychiatry assessments (see Section D.1). **Recommendation 2, March 2007:** Continue to monitor this requirement using process observation. **Findings:** Using the DMH Observation Monitoring Form, MSH reviewed an average sample of 7% (March to July 2007) based on a target population of the estimated total number of the WRPs due each month. The facility reported a mean compliance rate of 17% and attributed low compliance to the current staffing vacancies. Corrective actions include expedited efforts by discipline chiefs and Human Resources to interview potential candidates and streamline elements of the recruitment process. **Recommendation 3, March 2007:** Assess and correct factors related to low compliance with this requirement. **Findings:** MSH reported that participation of all team members has been impacted by vacancies and team coverage issues. Efforts to hire new staff and provide training to teams are ongoing. WRP process requirements have been integrated into the Psychiatric Physician's Manual (Team Leadership Section). Posters have been placed in all team conference areas. Discipline Chiefs, Team Leaders and Program Managers were provided results of internal monitoring data to assist them in efforts to improve compliance.

		Compliance: Partial. **Current recommendations**: 1. Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs. 2. Finalize efforts to streamline and standardize monitoring instruments that address quality of all disciplinary assessments. 3. Continue to monitor this requirement using process observation. 4. Expedite recruitment and training to improve compliance.
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to monitor this requirement using process observation. **Findings:** MSH used the DMH Observation Monitoring Form to assess compliance. Reviewing an average sample of 6% (March to July) of WRPs due each month, the facility reported a mean compliance rate of 22%. **Recommendation 2, March 2007:** Assess and correct factors related to low compliance rates. **Findings:** MSH reported that compliance has been impacted negatively by vacancies and mentoring/training needs. As mentioned earlier, corrective actions included integration of the WRP process requirements into the Psychiatric Physician's Manual (Team Leadership Section), placement of WRP Process Posters in all WRPC rooms and distribution of the results of internal monitoring to Discipline Chiefs. Team Leaders and Program Managers.

<table>
<tr>
<td></td>
<td></td>
<td>Compliance:
Partial.

Current recommendations:
1. Ensure that senior clinicians from all core disciplines provide ongoing feedback and mentoring to WRPTs.
2. Continue to monitor this requirement using process observation.
3. Expedite recruitment and training to improve compliance.</td>
</tr>
<tr>
<td>C.1.g</td>
<td>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Assess and correct factors related to the shortage of staff needed to implement the EP.

Findings:
MSH reported the following vacancies in core disciplines as of July 31, 2007:

<table>
<tr><th>Discipline</th><th>Vacancies (FTE)</th></tr>
<tr><td>Psychiatry</td><td>2</td></tr>
<tr><td>Psychology</td><td>12</td></tr>
<tr><td>Social Work</td><td>9</td></tr>
<tr><td>Therapeutic Services (RT)</td><td>5</td></tr>
<tr><td>Nursing (RN/PT)</td><td>20</td></tr>
</table>

MSH's Human Resources Department reported that five additional Social Workers and three Psychologists are scheduled to start during the month of August.

Other findings:
MSH used the Observation Monitoring process (March to July 2007) to assess compliance with the requirement to identify someone to be</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>responsible for implementation. A mean compliance rate of 45% was reported.

Chart review by this monitor (also see Sections C2 and D1) showed continued overall progress regarding the implementation of assessments and WRP reviews according to schedules required by the EP.

Compliance:
Partial.

Current recommendations:
Expedite recruitment efforts.</td></tr>
<tr><td>C.1.h</td><td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Assess and correct factors related to low compliance rates.

Recommendation 2, March 2007:
Continue to monitor the attendance by core team members.

Findings:
MSH has monitoring data to assess the attendance rate of all core members. The Process Roll-Call, derived from the Observation Monitoring Form, is the source of the data (March to July 2007). The following is a summary of the data for each core member. The number of observations varied from 36 to 51 per reporting month:

<table>
<tr><th>Core member</th><th>Mean attendance rate (March to July 2007)</th></tr>
<tr><td>Individual</td><td>83</td></tr>
<tr><td>Psychiatry</td><td>94</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><th>Core member</th><th>Mean attendance rate (March to July 2007)</th></tr>
<tr><td>Psychology</td><td>66</td></tr>
<tr><td>Social Work</td><td>75</td></tr>
<tr><td>Therapeutic Services (RT)</td><td>66</td></tr>
<tr><td>Nursing (RN)</td><td>91</td></tr>
<tr><td>Nursing (PT)</td><td>38</td></tr>
</table>

MSH reported that current vacancies in psychologist positions have impacted attendance rates for this discipline, and that a formal oversight system has been established to improve attendance by PTs.

Compliance:
Partial.

Current recommendations:
1. Continue current efforts to improve attendance by core members.
2. Continue to monitor this requirement and ensure a sample size of at least 20%.</td>
</tr>
<tr>
<td>C.1.i</td>
<td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Assess and correct factors related to low compliance rates for some disciplines.

Findings:
MSH assessed its compliance using the Consistent Enduring Team (CET) Report, which is completed monthly by the Assistant Treatment Enhancement Coordinator (March to July 2007). The facility reported the following data regarding the average caseloads for each core discipline. The data show that the admissions units have case loads that</td>
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<tr>
<td></td>
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<td>exceed plan requirements, particularly for the disciplines of psychology and social work and that the case loads on the long-term units are aligned with requirements of the EP.

ADMISSIONS
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>MD</td><td>15.8</td><td>16.3</td><td>16.6</td><td>16.8</td><td>17.4</td><td>16.6</td></tr>
<tr><td>PhD</td><td>16.9</td><td>16.8</td><td>17.8</td><td>26.8</td><td>19.8</td><td>19.6</td></tr>
<tr><td>SW</td><td>15.2</td><td>18.4</td><td>17.8</td><td>20.4</td><td>21.7</td><td>18.7</td></tr>
<tr><td>RT</td><td>14.2</td><td>16.1</td><td>16.0</td><td>16.0</td><td>16.5</td><td>15.7</td></tr>
<tr><td>RN</td><td>18.5</td><td>16.1</td><td>15.6</td><td>16.9</td><td>16.3</td><td>16.7</td></tr>
<tr><td>PT</td><td>16.0</td><td>16.8</td><td>14.3</td><td>14.7</td><td>15.2</td><td>15.4</td></tr>
</table>
LONG TERM
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>MD</td><td>22.1</td><td>22.0</td><td>22.0</td><td>21.6</td><td>23.9</td><td>22.3</td></tr>
<tr><td>PhD</td><td>25.2</td><td>24.0</td><td>23.2</td><td>23.0</td><td>21.3</td><td>23.3</td></tr>
<tr><td>SW</td><td>22.7</td><td>23.1</td><td>22.2</td><td>25.4</td><td>24.9</td><td>23.6</td></tr>
<tr><td>RT</td><td>22.0</td><td>22.0</td><td>21.0</td><td>22.3</td><td>21.5</td><td>21.8</td></tr>
<tr><td>RN</td><td>24.8</td><td>24.3</td><td>21.9</td><td>24.2</td><td>23.1</td><td>23.6</td></tr>
<tr><td>PT</td><td>24.4</td><td>23.5</td><td>21.1</td><td>22.6</td><td>21.2</td><td>22.5</td></tr>
</table>
Compliance:
Partial.

Current recommendations:
1. Expedite recruitment efforts for all core disciplines.
2. Resolve barriers related to recruitment of psychologists and social workers.</td>
</tr>
<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

	interdisciplinary wellness and recovery plans.	**Recommendation, March 2007:** Same as in C.1.a through C.1.f. **Findings:** Same as in C.1.a through C.1.f. **Other findings:** As mentioned earlier, MSH conducted monthly reviews of the number of members who have been trained and who received an 80% or greater score of the WRP Knowledge Assessment Test. The training was described in C.1.a. The mean compliance rate was 83% (March to July 2007). Staff who did not meet the competency threshold have been scheduled for the next training session. As mentioned earlier, this monitor's observations of WRPCs (and chart reviews) indicate that MSH has made some progress in the WRP process, but that overall progress has been insufficient to meet requirements of the EP. **Compliance:** Partial. **Current recommendations**: Same as in C.1.a through C.1.f.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. Kenneth Layman, Treatment Enhancement Coordinator 2. Nady Hanna, MD, President of Medical Staff 3. Bala Gulasekaram, MD, Chief, Department of Psychiatry 4. Lisa Rimland, WRP Trainer, Standards Compliance 5. Douglas Strosnider, Chief, CPS and Mall Director 6. Denise Knicks, Substance Recovery Coordinator 7. Swati Roy, PhD, Chief of Psychology, Co-Chair of BCC 8. Edwin Poon, PhD, Psychologist 9. Richard Hartley, PhD, Psychologist 10. Ashwind Singh, Psychology Intern 11. Susan Shifflett, Psychology Intern 12. Ana Peeks, PsyD, Psychologist 13. Leora Scheffres, PhD, Psychologist 14. Cindy Huang, PhD, Psychologist 15. Steve Young, PsyD, Psychologist 16. Brian Hough, PhD, Senior Psychologist 17. Wilma Fuentes, RN, PBS Team Member 18. Bo Kasperowicz, PT, PBS Team Member 19. Crystal Amey, PT, PBS Team Member 20. LaTasha Fields, PT, PBS Team Member 21. Katherine Nguyen, RN, PBS Team Member 22. Eric McMullen, PT, PBS Team Member 23. Al Munoz, PT, PBS Team Member 24. Gretchen Hunt, BY CHOICE Coordinator 25. Sean Johnson, Assistant BY CHOICE Coordinator 26. Cynthia Lusch, Clinical Administrator 27. Kerry Bert, Assistant Program Director 28. Fatimah Busran, MSW, Social Worker 29. Lee Breitenbach, CSW, Social Worker

		30. James Park, CSW, Social Worker 31. Shirin Karimi, LCSW, Chief of Social Work 32. Sonya Rock, ACSW, Social Worker 33. Jocelyn Agtarap, Nurse 34. Renee Kelley, Program Director, Program 6 35. Mary Uribe, PT 36. Gordon Walmin, PSW 37. Donald Magner, PT Mall Coordinator 38. Don Pieratt, PT, BY CHOICE Coordinator, Program V 39. Renee Mathis-Ryan, RT 40. Massha Jordan-Woods, RT 41. Elizabeth Matthew, PT 42. Grant Clarke, CSW 43. S. Maninang, PT 44. Ten individuals: LP, NV, AH, AB, LR, AB, RRC, JY, QV, and FG <u>Reviewed</u>: 1. The charts of 90 individuals: AF, AHW, AL, AMA, AZ, BB, BD, BR , BRB, BW, CC, CD, CG, CK, CMW, CTC, DM, DR, DRM, DS, DT, DW, DY, EL, FJK, FR, GB, GD, GG, HC, HL, IC, IG, IJD, IRC, JB, JC, JE, JG, JK, JM, JR, JRA, JRB, JS, JT, JW, KM, KR, LA, LB, LM, LO, LR, LW, MA, MAH, MC, MCF, MF, ML, MP, NH, NR, PD, PNL, PW, RAP, RB, RC, RDT, RG, RL, RM, RR, RU, RV, SB, SE, SFY, SG, SH, SJ, SMC, SW, SW-2, TM, TP, TS, and WH 2. MSH Discharge Planning Lesson Plan 3. DMH WRP Observation Monitoring Form 4. DMH WRP Observation Monitoring summary data (March to July 2007) 5. DMH WRP Chart Auditing Form 6. DMH WRP Chart Auditing summary data (March to July 2007) 7. DMH WRP Clinical Chart Auditing Form 8. DMH WRP Clinical Chart Auditing summary data (June & July 2007) 9. MSH data regarding Clinical Chart Auditing inter-rater training and

		reliability studies 10. Focus Audit summary data (August 2007) 11. Focus Audit summary data (March to July 2007) 12. WRP/Mall Alignment Check Protocol 13. WRP/Mall Alignment Monitoring Form 14. WRP/Mall Alignment Monitoring Form 15. WRP/Mall Alignment Monitoring Form Instructions 16. WRP/Mall Alignment Monitoring summary data (April 2007) 17. AD #3415, Screening Individuals for Substance Abuse (effective June 6, 2007) 18. List of clinical and process outcomes for individuals receiving Substance Recovery (SR) programs 19. Data regarding pre-test results (July and August 2007) for individuals receiving SR programs 20. Outline of SR Provider Training and Competency Evaluation, including the Clinical Evaluation Competency Training and Post-Test 21. MSH Substance Recovery Training Programs (16 domains) 22. List of all trained and verifiably competent SR providers 23. Lesson Plan Formats for Treatment Enhancement Staff Education and Training Sessions of SR Providers (Modules I to X) 24. The Substance Recovery Assessment and Treatment Recovery Auditing Form 25. The Substance Recovery Assessment and Treatment Recovery Monitoring summary data (May to July 2007) 26. MSH data regarding individuals reaching triggers for non-adherence to WRPs 27. MSH Strengths Survey 28. MSH Criteria for Determining Levels of Cognitive Functioning 29. List of Individuals Who Have Received Pre- and Post-Consultation 30. PSR MALL Facilitator Monthly Progress Note Template 31. Curriculum for Bed-Bound Residents 32. List of Enrichment Hours by Program 33. Group Leadership Training Record

		34. List of Individuals with High BMIs 35. Family Satisfaction Survey Template 36. List of Missed Appointments 37. PSR MALL Course Facilitator Consultation 38. Substance Recovery Group Evaluation Form 39. Substance Abuse Assessment and Treatment Audit Form <u>Observed</u>: 1. WRPC (Program III, unit 409) for monthly review of RD 2. WRPC (Program III, unit 401) for monthly review of JD 3. WRPC (Program II, unit 412) for monthly review of AT 4. WRPC (Program V, unit 407) for review of RJ 5. WRPC (Program VI, unit 419) for review of JP 6. WRPC (Program III, Unit 415) for review of JB 7. WRPC (Program III, Unit 415) for review of MA 8. WRPC (Program V, Unit 407) for review of CD 9. Five PSR Mall Groups: Stay Tuned, Bed-Bound Unit 418 and 419; Drug Education Program, Substance Recovery, Unit 409, Program 3; Communication Through Music, Unit 420, Program 6; Bridge to Recovery, Unit 409, Program 3; and Conflict Resolution, Unit 405, Program 5
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue WRP training that focuses on the process of engaging the individual in providing substantive input. **Findings:** The Engagement Curriculum (Module) has been used in all training sessions that were provided during this review period. As mentioned earlier, the facility provided only eight hours of training. The module adequately covers basic knowledge, including the role of team members

		in the process as well as practice vignettes. There have been no changes in the material covered in this module since the last monitor's report. **Recommendation 2, March 2007:** Address and correct factors related to low compliance with this requirement. **Findings:** MSH used the Observation Monitoring Form to assess compliance. The facility reviewed an average sample of 5% of WRPCs occurring in the reporting month (March to July 2007) and reported a mean compliance rate of 49% with this requirement. The facility recognized that compliance with this requirement has not improved since the last review and plans to provide mentoring to the teams to improve compliance. In addition, MSH has developed a list of recommended steps in the engagement of the individuals. The lists have been posted in the WRPC rooms. The steps capture requirements of the EP. **Compliance:** Partial. **Current recommendations:** 1. Increase WRP training sessions and provide ongoing feedback and mentoring to the teams regarding the process of engaging the individual in providing substantive input. 2. Correct factors related to low compliance with this requirement.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.

C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue implementation of the A-WRP within 24 hours of the admission. **Recommendation 2, March 2007:** Continue monitoring to ensure that A-WRPs are completed within 24 hours of all admissions. **Recommendation 3, March 2007:** Ensure that monitoring of the A-WRP includes 20% sample of all admissions. **Findings:** AD #3133, Wellness and Recovery Plan (July 6, 2007) specifies the required timelines for WRPCs. The timelines address the requirements of C.2.b.i through C.2.b.iii. The AD has been implemented throughout the hospital. MSH used the Chart Auditing Form to assess compliance (March to July 2007). The average sample size was 13%. The facility reported that vacancies in the Health Information Management Department (HIMD) have prevented obtaining an adequate sample size and that a new coordinator for HIMD has been appointed to ensure adequate sampling. The mean compliance rate was 100%. **Other findings:** This monitor reviewed the charts of 12 individuals who were admitted during this review period (JK, MAH, JC, IJD, SJ, LW, JB, JS, RAP, IC, SG and CTC). There was compliance in all charts.

		Compliance: Partial. **Current recommendations**: 1. Continue implementation of the A-WRP within 24 hours of the admission. 2. Continue monitoring to ensure that A-WRPs are completed within 24 hous of all admissions.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue implementation of the master WRP within seven days of the admission. **Recommendation 2, March 2007:** Continue monitoring of the master WRP within seven days of all admissions. **Recommendation 3, March 2007:** Ensure that monitoring of the master WRP is based on a 20% sample of all admissions. **Findings:** Using the WRP Chart Auditing Form, MSH reviewed an average sample of 16% (March to July 2007). The mean compliance rate was 81%. The facility reported that vacancies in clinical staff and scheduling problems have kept the scores under 100%. These factors are reportedly being addressed by increased recruitment, improved scheduling processes and a new system to ensure that team meetings not conforming to the published schedule are being followed up on by program managers.

		Recommendation 4, March 2007: Implement the DMH Clinical Chart Auditing Form. **Findings:** The tool has been implemented since June 2007. Training on this tool continues in an effort to improve the inter-rater reliability. The facility presented data regarding inter-rater reliability checks. Seven inter-disciplinary auditors received training and a reliability of 91% or more was established for five auditors. In addition, the Psychiatry department has conducted an inter-reliability study and reported an average score of 76% (actual vs. potential). The facility did not specify if a certain threshold was required before auditors can participate in monitoring. The facility anticipates that newly hired social workers will assist in improving the sample size. **Other findings:** Reviewing 12 charts, this monitor found compliance in 10 (JK, JC, IJC, SJ, LW, JB, RAP, IC, SG and CTC) and non-compliance in two (MAH and JS). The requirement for quarterly reviews did not apply in the chart of SG. **Compliance:** Partial. **Current recommendations**: 1. Continue implementation of the A-WRP within seven days of the admission. 2. Continue monitoring to ensure that A-WRPs are completed within seven days of all admissions, based on at least 20% sample.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every	**Current findings on previous recommendations:**

	30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Recommendation 1-3, March 2007:** 1. Implement the required WRP conference schedule on all teams. 2. Continue to monitor the implementation of the required WRP conference schedule on all admission and long-term teams. 3. Ensure that monitoring of the WRP reviews includes a 20% sample of all admissions. **Findings:** At present, MSH requires implementation of the WRP reviews in all units. The facility used the Chart Audit Form to assess compliance (March to July 2007). The facility reviewed an average sample of 16% of WRPCs (14-day, monthly, quarterly and annual). The mean compliance rate was only 19% for this requirement. The facility's assessment of low compliance and efforts to improve performance are the same as mentioned in C.2.b.ii. **Recommendation 4, March 2007:** Implement the DMH Clinical Chart Auditing Form. **Findings:** Same as in C.2.b.ii (recommendation #4). **Other findings:** Chart reviews by this monitor showed partial compliance in six charts (JK, MAH, JC, IJD, RAP and CTC), compliance in three (SJ, LW and SG) and non-compliance in one (IC). The requirement for WRP reviews every 14 days and for subsequent reviews did not apply in the charts of JB and JS. **Compliance:** Partial.

		Current recommendations: Continue monitoring to ensure that all WRP reviews are completed within the required timeframes, based on at least a 20% sample.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Implement the DMH Clinical Chart Auditing Form to monitor this requirement and address the deficiencies identified above. **Findings:** MSH has implemented this recommendation. Using the Clinical Chart Auditing Form (June and July 2007), the facility reviewed an average sample of 5% (the sample size was improved in June). The total target population (N) was appropriately calculated as the number of monthly (after first quarterly), quarterly and annual WRPs due per month. MSH reported a mean compliance rate of 56% with this requirement. Efforts to improve inter-rater reliability are ongoing. The facility anticipates that compliance will improve as a result of increased training on case formulation, foci, objectives and the development of appropriate interventions (using the PSR Mall catalog). **Recommendation 2, March 2007:** Continue training of WRPTs to ensure that: a) The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b) Foci of hospitalization address all identified needs of the individual in the above domains. **Findings:** The Case Formulation and the Foci and Objectives Modules are being used in all training sessions. The facility developed a worksheet

		outlining appropriate components to be addressed in the development of the case formulation. The worksheets have been posted in the WRPC rooms. As mentioned earlier, the facility provided 24 hours of WRP training (Phase II) during this interval. Additionally, in order to correct the deficiencies outlined by this monitor (see Other findings below), MSH must provide ongoing feedback and mentoring of the teams (Phase III training). **Other findings:** This monitor reviewed the charts of individuals suffering from a variety of cognitive impairments and seizure disorders. The reviews indicate that treatment and rehabilitation services still ignore some important needs of these individuals. The following are chart examples of individuals in each category: 1. Individuals diagnosed with cognitive impairments (SE, DT, BRB, AMA, PNL, JB, HC, RG and KR): a) The WRP does not include focus of hospitalization or objectives/interventions for individuals diagnosed with Amnestic Disorder due to Head Trauma (PNL), Moderate Mental Retardation (JB) and Mild Mental Retardation (KR). b) The focus of hospitalization does not delineate behaviors that can be targeted for treatment/rehabilitation and/or further assessment for an individual diagnosed with both Dementia due to Cerebral Anoxia with Behavioral Disturbance and Mental Retardation, Severity Unspecified (RG). c) The objectives and/or interventions are not related to the focus of hospitalization for individuals diagnosed with Alcohol-Induced Persisting Dementia and Dementia Due to Head Trauma (HC) and Cognitive Disorder, NOS (AMA). d) The interventions do not include an assessment of the possible negative impact of current treatments on individuals

		diagnosed with Borderline intellectual Functioning (BRB) and Cognitive Disorder, NOS (AMA). e) In general, the present status section does not address the status of these individuals' cognitive dysfunction. f) The interventions related to cognitive remediation are generally inadequate and/or insufficient. 2. Individuals diagnosed with seizure disorders (BRB, GB, MA, SB and LB): a) The WRPs contain an objective that is not attainable for the individual and that fails to include any learning-based outcomes. b) The present status section of the WRP does not address the status of the individual's seizure activity during the previous interval in almost all cases. c) The WRPs do not include objectives/interventions to assess the risks of treatment and to minimize its impact on the individual's behavior and cognitive status. See monitor's findings in C.2.o regarding individuals suffering from substance use disorders. **Compliance:** Partial. **Current recommendations**: 1. Continue monitoring using the DMH Clinical Chart Auditing Form, based on at least a 20% sample. 2. Increase training of WRPTs and provide ongoing feedback and mentoring, to ensure that: a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization, objectives and interventions address all

		identified needs of the individual in the above domains.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as in C.2.c. **Findings:** Same as in C.2.c. **Recommendation 2, March 2007:** Continue the case formulation training related to this requirement and ensure that the training includes clinical case examples. **Findings:** The facility has implemented training based on the Case Formulation Module during this review period. Clinical case examples are currently used by the DMH Consultant who is providing the training. Documents utilized in the training include the individual's integrated assessments, WRPs, monthly progress notes, case formulation worksheets, task tracking sheets and DSM Checklists. This training is appropriate to this requirement, but the facility needs to increase sessions and proceed to provide ongoing feedback and mentoring to the teams (Phase III).

		Recommendation 3, March 2007: Implement the Clinical Chart Auditing Form to monitor this requirement and ensure a 20% sample of the target population. **Findings:** MSH used the Clinical Chart Auditing Form to assess compliance with this requirement. Reviewing an average sample of 5% (March to July 2007), the facility reported a mean compliance rate of 53% for this item. The compliance rates for requirements in C.2.d.ii through C.2.d.vi are listed in each corresponding sub-cell below. The facility recognizes that further training is needed to assist the teams in improving compliance in this section. **Recommendation 4, March 2007:** Address and correct factors related to low compliance. **Findings:** Same as findings under Recommendation 2 above. **Other findings:** Almost all the charts reviewed by this monitor showed lower compliance rates than those reported by the facility. Mentoring and ongoing feedback to the teams are needed to improve compliance with the requirements in all the sub-cells of this section and to address the following persistent general deficiencies: 1. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. For example, the present status sections do not include needed information in the review of the use of restrictive interventions, the clinical progress of individuals suffering from a variety of disorders and high-risk behaviors, and the individual's progress towards discharge.

		2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). These deficiencies must be corrected in order to achieve substantial compliance with this requirement. **Current recommendations**: 1. Increase case formulation training and ensure that the training includes clinical case examples, ongoing feedback and mentoring by senior clinicians. 2. Continue to monitor this requirement using the Clinical Chart Auditing Form and ensure a 20% sample of the target population.
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	33%
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	18%
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment	45%

	and rehabilitation interventions;	
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	45%
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	38%
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Findings:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Other findings:** Using the Chart Audit Form, MSH reviewed an average sample of 15% (March to July 2007) and reported a mean compliance rate of 1% with this requirement. This process was also used to assess compliance with the requirements in C.2.f.i through c.2.f.v. (the mean compliance rate for each corresponding sub-cell is listed below). In addition to this audit, which was performed by staff from the HIMD, the program managers conducted a Focused Audit reviewing two charts per team (53 charts) in August 2007. This mechanism utilized

indicators that are tailored to sub-components of each requirement in C.2.e. and C.2.f.i through C.2.f.v. However, the data presented by MSH facility did not properly align the indicator with the requirement in each sub-cell. The following is an outline of the indicators relevant to all the requirements in C.2.e and C.2.f. This monitor reorganized the facility's indicators considering the overall structure of the WRP. The corresponding mean compliance rates (for Programs I through V) are as follows:

1.	*There is a focus of hospitalization for each Axis I, II and III diagnosis*	33%
2.	*There is a focus for each discharge criteria*	25%
3.	*Each focus has an objective and an intervention*	33%
4.	*There is documented rationale in the Focus area if any Focus of hospitalization does not have an objective or an intervention*	0%
5.	*All objectives are written in a way that tells you what we will see or hear the individual doing*	6%
6.	*Each objective includes a staff intervention in the therapeutic milieu*	7%
7.	*The objectives begin with the individual's current stage of change and end at the maintenance stage*	2%
8.	*All objectives for Focus 1, 3 and 5 are linked to the individual's stages of change (SOC)*	8%
9.	*Each objective includes a staff intervention in the therapeutic milieu*	7%
10.	*The individual's strengths are used in the interventions*	4%
11.	*Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day*	6%
12.	*Interventions are aligned with their respective objective and they specify the name(s) of specific staff responsible for implementing each intervention, type of*	0%

			intervention, and frequency and duration of the intervention	
		13.	*There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR Mall*	4%
		14	*There are specific groups or individual therapy linked to specific objectives that focus on treatment (e.g., treatment of a specific medical or psychiatric condition) and are provided in the PSR Mall*	6%
		15.	*There are specific leisure and recreational groups specified in the interventions that are linked to objectives derived from Focus 10*	1%

The facility reported that poor compliance with this requirement, as well as requirements in C.2.f.i through C.2.f.v, is a result of poor alignment between objectives and interventions, lack of specificity within these sections, and multiple deficiencies in the interventions section regarding the identification of staff names, group dates and times, and inclusion of milieu interventions.

Other findings:
Chart reviews by this monitor indicate that, in general, deficiencies in the following areas have yet to be corrected:

1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o).
2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f).
3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g).

These deficiencies must be corrected in order to achieve substantial compliance.

		Compliance: Partial. **Current recommendations**: Same as in C.2.c, C.2.f, C.2.g and C.2.o.
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue and reinforce training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual. **Findings:** The objectives and interventions curriculum has been used during all training sessions. **Recommendation 2, March 2007:** Implement the Clinical Chart Auditing Form to monitor this requirement. **Findings:** This recommendation was unnecessary. Monitoring for this item has

		been completed using the Chart Audit Form, which is sufficient. Using this form, the facility reviewed an average sample of 15% (March to July 2007). The mean compliance rate for this requirement was 4%. **Recommendation 3, March 2007:** Address and correct factors related to low compliance with this requirement. **Findings:** The facility reviewed results of the Focus Audit (August 2007), summarized in C.2.e above. Based on this assessment, the facility concluded that the low compliance in this area is a result of the individual's strengths not being utilized when writing interventions in the WRP, the lack of documentation when a focus has no objective and the poor alignment with the stage of change. **Other findings:** This monitor reviewed six charts (FJK, DRM, JC, JRA, MAH and LM). The review showed non-compliance in five charts and compliance in one (MAH). **Compliance:** Partial. **Current recommendations**: 1. Increase training sessions regarding objectives and interventions, and provide ongoing feedback and mentoring by senior clinicians. 2. Continue to monitor this requirement based on at least a 20% sample. 3. Continue to assess factors related to low compliance and provide corrective actions.

C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Other findings:** MSH used the Chart Audit Form (March to July 2007). Reviewing an average sample of 15%, the facility reported a mean compliance rate of 1%. Based on a review of the Focus Audit results (August 2007), MSH assessed that poor compliance is a result of the limited number of leisure or recreational group interventions and poor linkage between the objectives and interventions. Often, the corresponding focus (#10) was not identified in the WRP. In addition, skill training and support groups were not well linked to an objective or found in the PSR Mall interventions. This monitor reviewed seven charts (FJK, DRM, JC, JRA, MAH, LM and MHW) and found compliance in only one (MHW). **Compliance:** Partial. **Current recommendations:** Same as above.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above.

		Findings: Same as above. **Other findings:** The Chart Audit data (average sample of 15%) showed a mean compliance rate of 7%. The facility assessed that the low compliance is a result of ongoing difficulties of WRPTs to consistently write objectives that are behavioral, observable and/or measurable. Often, the audit would identify that most of the objectives met criteria but that one or two objectives were poorly written, resulting in non-compliance. In reviewing six charts (FJK, DRM, JC, JRA, MAH and LM), this monitor found non-compliance in five charts and partial compliance in one (MAH). **Compliance:** Partial. **Current recommendations**: Same as above.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Other findings:** The facility's data were derived from the Clinical Chart Audit (March to July 2007). The mean compliance rate was the same as that listed

		for the requirement in C.2.f.iii. As mentioned earlier, the facility reviewed results of the Focus Audit (August 2007) to assess its low compliance. Based on this process, the facility concluded that the main factors involved incorrect or incomplete delineation of the stages of change and improper alignment of the stages and the corresponding objectives and interventions. This monitor reviewed six charts and found non-compliance in four (FJK, DRM, JC, MAH and LM) and partial compliance in one (JRA). **Compliance:** Non-compliance. **Current recommendations**: Same as above.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Other findings:** The Chart Audit data showed a mean compliance rate of 0%. The review, by MSH, of the Focused Audit (August 2007) showed that poor progress in meeting this requirement was a result of alignment problems between the objectives and interventions. In addition, interventions often did not indicate staff names and/or frequency and duration of interventions. Reviewing six charts (FJK, DRM, JC, JRA, MAH and LM), this monitor

		found non-compliance in all cases. **Compliance:** Non-compliance. **Current recommendations:** Same as above.
C.2.f.vi	implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals **Findings:** MSH is addressing this requirement by training teams to increase the number of active treatment interventions for individuals in their WRPs. In addition, training has been provided to improve the alignment between the objectives of the WRPs and corresponding Mall interventions. Training involved providing WRPT members with copies of the Mall schedule, forms and procedures for scheduling that assist in the alignment between the individual's WRP and Mall schedule. In addition, MSH plans to increase monitoring by program managers and Mall staff of individuals' Mall attendance. **Recommendation 2, March 2007:** Continue efforts to monitor hours of active treatment (scheduled and attended). **Findings:** MSH presented information regarding the number of individuals who

were scheduled for Mall activities and are attending these activities and the hours of attendance per week. The following table outlines the data:

	Mar	Apr	May	Jun	Jul	Mean
N	657	674	683	669	681	673
n	626	727	704	710	745	702
%S	95	108	103	106	109	104
						Hours
0-1	45	49	38	64	66	52
1-5	147	118	129	127	149	134
6-10	147	174	145	124	149	148
11-15	155	182	192	186	205	184
16-19	99	137	174	178	155	149
20+	33	18	26	31	21	26

N=Average daily census per month.
n=number of individuals scheduled and attending per month (exceeded N in some months due to number of admissions and discharges per month).

The facility's data showed that most individuals have yet to receive the required hours of active treatment but that an upward trend is noted in the number of individuals attending 11-19 hours per week. The facility reported that this trend is consistent with an increase in the percentage of groups held and a decrease in the rate of group cancellations due to improved administrative oversight.

Other findings:
This monitor reviewed eight charts (MAH, LM, JC, LW, SMC, AHW, WH and SW) to determine the documentation of active treatment hours listed on the most recent WRP. The corresponding MAPP data regarding hours scheduled and attended were also reviewed. The reviews showed the following:

		1. Only two charts (AHW and SW-2) included evidence that the teams scheduled the required number of hours. 2. There continues to be inconsistency between WRP and MAPP data regarding scheduled hours and actual hours attended. **Compliance:** Partial. **Current recommendations**: 1. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals. 2. Continue to monitor hours of active treatment (scheduled and attended).
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Monitor a 20% sample of civilly committed individuals. **Findings:** MSH used the Chart Audit Form (March to July 2007). Based on an average sample of 15%, the facility reported a compliance rate of 1%. **Recommendation 2, March 2007:** Assess and correct factors related to lack of programs. **Findings:** The facility conducted a Focus Audit to assess factors related to low compliance with this requirement. The audit reviewed units 101,105, 410, 412, 414 and 416, as appropriate to this requirement. The reviews

		were conducted for the months of March to July 2007 and focused on the number of individuals appropriate for community-based services, the number of individuals receiving community-based interventions and the number of groups provided. However, the facility's data demonstrated a lack of understanding of this requirement. This is evident by the inclusion of Mall activities as community-based services. In addition, the data contained occasional inaccuracies regarding the number of individuals receiving the activities versus those identified to be appropriate for the activities. The facility reported that, in some cases, the WRPTs did not list community-based interventions even when individuals were attending such activities. The facility recognized that lack of formal oversight contributed to low compliance. **Other findings:** This monitor reviewed the charts of five individuals admitted under civil commitments. There was non-compliance in all cases (WH, SW, AHW, WH and SW-2). **Compliance:** Non-compliance. **Current recommendations**: 1. Continue to monitor this requirement using at least a 20% sample. 2. Continue to assess factors related to lack of programs and provide corrective actions.
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Implement mechanisms to ensure proper linkage between type and objectives of Mall activities and objectives outlined in the WRP as well as documentation of this linkage.

	requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Findings:** MSH reported that Mall catalogs have been provided to all teams in order to better select the best group(s) to ensure this alignment. In the last review report, the facility reported a number of mechanisms that were summarized in the findings under Recommendation 1 in this cell. However, at this time, the facility is unable to report if progress has occurred in this area. **Recommendation 2, March 2007:** Revise the WRP/Mall alignment check protocol to address this requirement. **Findings:** The DMH has revised the Mall Alignment Monitoring Form (June 2007). The form has instructions that are appropriate to this requirement. The DMH WRP/Mall Alignment Monitoring Form has been approved for use. The facility initiated training of the auditors regarding the use of this form and initiated a process for ensuring inter-rater reliability. Data from the previous tool show that some interventions have sufficient linkage with the corresponding objective. Mall catalogs have been provided to all teams in order to better select the best group(s) to ensure this alignment. **Recommendation 3, March 2007:** Continue the implementation of electronic progress notes by all Mall and individual therapy providers. **Findings:** MSH reported that the electronic version of the progress notes has been available on the facility's network for use by all providers. MSH has identified an administrative mechanism to ensure that the Mall notes are being implemented by all Mall providers by October 1, 2007. The new WaRMSS WRP, when implemented, should ensure progress

		note integration. **Recommendation 4, March 2007:** Ensure that WRPTs integrate data from the Mall progress notes in the review and modification, as needed of the WRPs. **Findings:** MSH reported that WRPTs have received training regarding this recommendation. The facility anticipates improved practice with increased use of the electronic progress notes by Mall providers and improved documentation of the Present Status section of the case formulation. **Other findings:** The facility presented data based on the old Mall Alignment Monitoring Form, but the data were not relevant to this requirement. This monitor reviewed the charts of six individuals (FJK, DRM, JC, JRA, MAH and LM) to determine if Mall groups were appropriately linked to the WRP objectives. The review showed partial compliance in five cases and compliance in one (LM). **Compliance:** Partial. **Current recommendations:** 1. Provide documentation of current mechanisms used to improve linkage, and report on progress made in this area. 2. Ensure implementation of electronic progress notes by all Mall and individual therapy providers. 3. Ensure that WRPTs integrate data from the Mall progress notes in the review and modification, as needed of the WRPs.

C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. **Findings:** The WRP training curriculum includes a requirement for review and revision of foci/objectives. In addition, the requirement is listed in the Psychiatric Physician's Manual as part of the section regarding Wellness and Recovery Planning. However, as mentioned earlier, MSH provided insufficient training during this review period. **Recommendation 2, March 2007:** Monitor this requirement using both process observation and chart auditing. **Recommendation 3, March 2007:** Add an indicator to address this requirement in the DMH Clinical Chart Auditing Form. **Findings:** MSH used the WRP Observation Monitoring Form, MSH reviewed an average sample of 5% (March to July 2007). The mean compliance rate

		was 61%. In addition, the facility used the Clinical Chart Auditing Form (June and July 2007). Reviewing an average sample of 4%, the facility reported a mean compliance rate of 4% with this requirement. The current indicators used on the Clinical Chart Auditing Form are aligned with the requirement. **Recommendation 4, March 2007:** Address and correct factors related to low compliance. **Findings:** The facility reported that efforts to increase the number of Mall progress notes are expected to enhance compliance with this requirement. **Other findings:** This monitor reviewed the charts of six individuals (FJK, JC, MAH, LM, LW and SMC) and found non-compliance in all cases. **Compliance:** Partial. **Current recommendations**: 1. Increase training sessions to WRPTs, including ongoing feedback and mentoring by senior clinicians, to ensure that foci and objectives are reviewed and revised, and that new interventions are developed and implemented as clinically needed. 2. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 3. Provide corrective actions to ensure consistent implementation of the Mall progress notes and the integration of available notes to ensure timely and appropriate revisions of the WRP.

C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as above. **Findings:** Same as above. **Recommendation 2, March 2007:** Revise current monitoring tool to include individuals whose functional status has improved. **Findings:** MSH has yet to implement this recommendation. **Recommendation 3, March 2007:** Implement the DMH Clinical Chart Auditing Form. **Findings:** The facility currently uses the WRP Observation Monitoring and Chart Audit Forms, which is sufficient to monitor this requirement. **Other findings:** Using the WRP Observation Monitoring Form (March to July 2007), MSH reviewed an average sample of 4%. The mean compliance rate was 67%. However, data based on the Chart Audit Form (March to July 2007) showed mean compliance rate of 5% (average sample was 2% of the 7-day, 14-day, monthly, quarterly and annual WRPCs). These data indicate that the teams are more able to address this requirement in practice than to document performance of this task. MSH assessed that consistent review of the WRP attachment form will improve compliance with this requirement and that the teams are being

		reminded to use this form. This monitor reviewed the charts of five individuals who experienced restrictive interventions during this review period (LM, JC, LW, SMC and BR). There was non-compliance in four charts and compliance in one (BR). The main deficiencies are found in the present status section and are summarized as follows: 1. There is no review of the circumstances of the use of seclusion and/or restraints or treatment modifications to reduce the risk of future use (JC, LW and SMC) 2. The circumstances of the use of restrictive interventions are reviewed, but without documentation of appropriate modifications of interventions to reduce the risk (LM). **Compliance:** Partial. **Current recommendations**: 1. Implement corrective actions to improve and ensure compliance, in particular: a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Continue to monitor this requirement using at least a 20% sample. 3. Revise current monitoring tool to include individuals whose functional status has improved.
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs,	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue training of WRPTs to ensure consistent implementation of this

	consistent with his/her legal status; and	requirement. **Findings:** The facility provided this training as part of the Engagement and Discharge Planning Curricula. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** MSH used the WRP Observation Monitoring and Clinical Chart Auditing Forms to assess compliance. The Observation Monitoring data (March to July 2007) were based on an average sample of 6% and showed a mean compliance rate of 38%. However, the Clinical Chart Audit data (June and July 2007) that the facility presented did not relate to this requirement. **Recommendation 3, March 2007:** Address and correct factors related to low compliance. **Findings:** The facility assessed that factors impacting low compliance included the lack of Mall progress notes and the WRPTs' limited review of the available notes and of the foci that represent barriers to discharge. **Other findings:** This monitor reviewed the charts of five individuals (FJK, DRM, JC, JRA and MAH). There was partial compliance in almost all cases. The following is a summary of the monitor's findings: 1. The discharge criteria were adequately documented in four charts (FJK, DRM, JRA and MAH). 2. The discharge criteria were sufficiently individualized in view of

		the legal commitment status. 3. The present status section did not document the team's discussion regarding the individual's progress towards discharge (FJK, DRM, JC and JRA). **Compliance:** Partial. **Current recommendations:** 1. Same as in C.2.g.i. 2. Increase training sessions to WRPTs, including ongoing feedback and mentoring by senior clinicians, to ensure that barriers related to discharge are addressed using appropriate foci, objectives and interventions.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, March 2007:** Same as in C.2.f.viii. **Findings:** Same as in C.2.f.viii. **Other findings:** MSH used the WRP Observation Monitoring Form to assess compliance (March to June 2007). Reviewing an average sample of 6%, the facility found a mean compliance rate of 31%. The lack of Mall progress notes

		was thought to be the main factor impacting compliance. This monitor reviewed the charts of five individuals (FJK, DRM, JC, JRA and MAH). There was non-compliance in all cases due to the following two main deficiencies: 1. The Mall progress notes were not completed (DRM, JRA and MAH). 2. When the Mall notes were present, the teams did not integrate the information in these notes to modify the WRP (FJK and JC). **Compliance:** Partial. **Current recommendations**: 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all PBS plans are trained to certification across environments before implementation. **Findings:** MSH used item #2 of the DHM Psychological Services Monitoring Form to address this recommendation, reporting an average compliance rate of 31% for March through July, 2007. The table below with its monitoring indicator showing the number of active PBS plans (N) between March and July, 2007, and the number of PBS plans with integrity checks (n), is a summary of the facility's data. The development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of

<table>
<tr>
<td></td>
<td></td>
<td>the interventions, providing staff training regarding program implementation, and as appropriate, revising or terminating the program.

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>13</td><td>12</td><td></td></tr>
<tr><td>n</td><td>8</td><td>2</td><td>2</td><td>10</td><td>12</td><td></td></tr>
<tr><td>%S</td><td>62</td><td>18</td><td>18</td><td>77</td><td>100</td><td></td></tr>
<tr><td>%C #2</td><td>8</td><td>0</td><td>50</td><td>40</td><td>58</td><td>31</td></tr>
</table>

This monitor reviewed the plans and noticed that in all cases staff training had been conducted prior to the implementation of the plans. However, MSH decided to report only the plans that had integrity checks, even when the staff for the specific plan was trained.

MSH provided training to staff responsible for implementing intervention plans. This monitor verified staff training/certification of 11 cases (JK, JG, DY, AF, MC, MP, NR, RM, PW, FR, and RL) prior to implementation of the intervention plans. Only three of them (NR, FR, and RL) included competency scores.

Compliance:
Partial.

Current recommendations:
Ensure that all PBS plans are trained to certification across environments before implementation.</td>
</tr>
<tr>
<td>C.2.i</td>
<td>Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:</td>
<td>Compliance:
Partial.</td>
</tr>
</table>

C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities. 2. The WRPT should integrate these assessments and prioritize the individual's assessed needs. **Findings:** This monitor reviewed discipline-specific assessments and found that only the psychology assessment included an "Implications for Rehabilitation Services" statement. The other disciplines have yet to include this statement in their assessments, and thus were not audited for this recommendation. According to Ken Layman, Treatment Enhancement Coordinator, discipline chiefs from MSH are working with chiefs from other facilities on meeting this recommendation for their respective disciplines. This monitor reviewed ten WRPs (RL, TP, MV, PD, DM, LO, RC, CC, BW, and DS). Information from the assessments were incorporated into the individual's WRP in seven of them (CC, RC, LO, RL, MV, PD, and DM), and three of them (DS, TP, and BW) did not include all the relevant information or prioritize the information into the individual's needs. Furthermore, the assessments failed to include pertinent information important for the individual's PSR services and Discharge Planning. For example, Axis IV includes information on lack of support, family support, housing (LO, TP, DM, RL, and PD), but this information was not included in the "Implication for rehabilitation services" statement. **Recommendation 3, March 2007:** The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to

		choose from these interventions. **Findings:** MSH did not audit this recommendation. According to Ken Layman, WRPTs have been given spreadsheets with group information. Five individuals (AH, AB, LR, AB, and RRC) interviewed by this monitor, and WRPT members indicated that the individuals were given the opportunity to choose activities with the assistance from the WRPT. **Recommendation 4, March 2007:** Ensure that group leaders are consistent and enduring for specific groups. **Findings:** MSH did not audit this recommendation. According to Ken Layman, data on consistent and enduring facilitators is to be evaluated through analysis of the Mall spreadsheet. A number of individuals (RJ AB, and JY) reported to this monitor that they were not motivated to attend PSR Mall groups because facilitators were not consistent. RJ, for example, stated that he is not attending groups because the usual instructor was not leading the group. **Recommendation 5, March 2007:** Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. **Findings:** MSH has set a criterion of seven consecutive absences of the individual from his/her assigned groups as the trigger to engage the individual in interventions to encourage participation in the Mall groups. MSH has

		provided training to clinical staff in motivational interviewing, narrative therapy, and cognitive behavioral interventions. However, MSH has not audited individuals who met the criterion for interventions. **Current recommendations:** 1. All discipline-specific assessments should include a section that states the implications of the assessment for rehabilitation activities. 2. The WRPT should integrate these assessments and prioritize the individual's assessed needs. 3. The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions. 4. Ensure that group leaders are consistent and enduring for specific groups. 5. Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendation 1-3, March 2007:** 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that the learning outcomes are stated in measurable terms. 3. Ensure that each objective is directly linked to a relevant focus of hospitalization. **Findings:** According to Ken Layman, MSH did not report data on these recommendations at this time because staff training on inter-rater reliability has not been completed. MSH is currently reviewing cases and would prefer to report the data when reliability training has been

completed. However, MSH did use #7 from the DMH WRP Chart Audit Form to address Recommendation 1, reporting 12% compliance. The table below with its monitoring indicator showing the number of WRPs (N), for each month from march through July 2007, and the number of WRPs audited (n), and the compliance obtained (%C) is a summary of the facility's data.

The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.

	Mar	Apr	May	Jun	Jul	Mean
N	653	674	810	683	659	
n	102	144	87	116	81	
%S	16	21	14	14	12	
%C -7	18	17	12	7	7	12

This monitor reviewed eight charts (AL, CD, LR, JM, DY, PW, TP, and ML). Four of them (AL, CD, LR, and JM) had each of their objectives written in behavioral terms, and four of them (DY, PW, TP, and ML) did not.

This monitor also reviewed 11 charts (ML, DY, JM, LR, CD, AL, TP, PW, RL, KM, and RB). Six of them (ML, DY, JM, LR, CD, and AL) had their objectives aligned with their respective foci, and five of them (TP, PW, KM, RL, and RB) did not.

Finally, this monitor reviewed an additional 11 charts (FA, AZ, JE, RU, DR, RDT, MCF, IRC, KM, NH, and GD). Four of them (FA, AZ, JE, and RU) had written objectives that were observable/measurable, and seven of them (DR, RDT, MCF, IRC, KM, NH, and GD) had one or more objectives that were not written in an observable/measurable manner.

		Current recommendation: Ensure that each objective is directly linked to a relevant focus of hospitalization.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** Please see Findings in C.2.i.ii. **Recommendation 2, March 2007:** Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. **Findings:** This monitor reviewed nine charts (JM, LR, CD, AL, ML, TP, PW, RL, and RB). Four of them (JM, LR, CD, and AL) met criterion, and five of them (ML, TP, PW, RL, and RB) did not. **Recommendation 3, March 2007:** When assigning Mall groups, the WRPT members should use the Mall Catalogue so that the groups they recommend are aligned with the individual's needs, stage of change and cognitive level. **Findings:** MSH did not report any data for this recommendation. According to Key Laymen, Mall course catalogues have been distributed to all teams, and training provided on auditing this recommendation. MSH plans to automate this system using WaRMSS.

		This monitor's interview of WRPT members indicated that they are aware of the Mall catalogues and refer to them when they are not certain about any of the PSR Mall group content. This monitor did not observe any Mall course catalogue being referred to or made available during the conferences observed. This monitor reviewed the MSH Mall Catalogue, Spring, 2007. The catalogue identifies the Focus, group title, stages of change, level of functioning, facilitators, day and time, and location, as well as a brief description of the course content. All columns were not completed in the catalogue. Description of the groups varies in their presentation. A few emphasize the activity itself (for example, the description of Art in Mental Health, activity #1058, is, "Individuals participating in these workshops will have the opportunity to explore and learn various visual art media which may include painting, design, drawing, sculpture, photography, cultural crafts, ceramics, collage, mural making and print making. Completed pieces may be displayed at various art exhibits both at the facility and in the community,") while others emphasize both the activity itself and what the individual could gain from a social and psychological perspective (for example, the description of Basketball, activity #1193, is, "to provide a format for clients to play a competitive game that will help them attain a sense of inner accomplishment, to help develop the ability to delay gratification and learn skills related to social skills, tolerance and frustration,"). Course developers should follow the basketball activity description as an example. **Other findings:** MSH has shown that Mall services do not have to be interrupted because of other concurrent activities. According to Ken Layman, DBT was conducted for all staff in Program 2 without having to cancel any of the Mall groups involved.

		Current recommendations: 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. 3. When assigning Mall groups, the WRPT members should use the Mall Catalogue so that the groups they recommend are aligned with the individual's needs, stage of change and cognitive level.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that group facilitators and individual therapists use the Individual Strengths Survey. **Findings:** According to Ken Layman, Individual Strengths Surveys are available in the Mall offices, and also have been distributed to all WRPTs for inclusion in the individual's WRP. MSH used item #5 (*utilizes the individual's strengths, preferences, and interests*) from the DMH WRP/Mall Alignment Monitoring Form and found that few facilitators and individual therapists were using the information from the Individual Strengths Survey. **Recommendation 2, March 2007:** Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these. **Findings:** This monitor reviewed 15 charts (RDT, JE, RU, HL, AZ, DR, MCF, NH, IG, BB, LA, CK, SFY, GD, and IRC). Four of them (RDT, JE, RU, and HL)

		had the individual's strengths, preferences, and/or interests clearly specified in the interventions of the individual's WRP, and 11 of them (AZ, DR, MCF, NH, IG, BB, LA, CK, SFY, GD, and IRC) did not include such information. In the case of SFY, one statement at the end of all interventions, "Ms. Y is able to openly articulate her thoughts and needs. She does not isolate herself from others" was listed as a strength for all interventions. **Current recommendations:** 1. Ensure that group facilitators and individual therapists use the Individual Strengths Survey. 2. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. **Findings:** This monitor reviewed ten charts (DW, DY, CD, MC, SH, JT, CG, SW, LR, and JM). One of the ten (DW) WRPs had documented evidence that more than one team member participated in the proceedings, and there was no such evidence in the remaining nine (DY, CD, MC, SH, JT, CG, SW, LR, and JM). Five of the same charts (DW, SH, JT, SW, and JM) included sufficient information regarding the individual's vulnerabilities in the case

		formulation under predisposing, precipitating, and perpetuating factors, and the remaining five (DY, CD, MC, LR, and CG) did not fully address the individual's vulnerabilities. **Recommendation 3, March 2007:** Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. **Findings:** MSH did not audit this recommendation. According to Ken Layman, WRPT members have been trained on the proper development of the Present Status section. Further training and mentoring will be needed to improve team performance. This monitor reviewed seven charts (MC, SH, CG, JM, DY, CD, and DW). Two of them (MC and SH) addressed the individual's vulnerabilities in the Present Status section of the WRP, and five of them (CG, JM, DY, CD, and DW) did not provide any meaningful information regarding the individual's current/present status of his/her vulnerabilities. **Recommendation 4-5, March 2007:** 4. Use the staged model of substance abuse training for group facilitators. 5. Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. **Findings:** According to Ken Layman, MSH continues to train substance abuse group providers using the staged curriculum s, and presently is training providers at the stage 1 and 2 competency levels. MSH's training curriculum is based on the book "Group Treatment for Substance Abuse" by Velasquez et al. Currently, only 21% (11/51 groups) of the groups are following the new curriculum. Three of the groups are being

offered twice a week and the remaining eight are offered once a week.

This monitor's findings from review of training documents, Mall catalogs, Mall schedules, and discussion with the Mall Director are in agreement with MSH's report.

Recommendation 6, March 2007:
Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.

Findings:
According to Ken Layman, Mall coordinators and Program Managers were provided with WRAP materials and directed to include adequate numbers of WRAP groups in the new Mall schedule.

MSH has increased the number of WRAP groups offered in Malls. The table below showing the number of WRAP groups offered at each Mall Center from March through August 2007 is a summary of the facility's data. The table shows an increase over time in the number of WRAP groups offered in Mall groups.

	Mar	Apr	May	Jun	Jul	Mean
Disc Bay	0	1	1	1	1	1
DB 404	0	1	1	1	2	1
Outward B	0	3	4	4	4	3
Bridge Recovery	7	5	5	5	8	6
New Horizon	0	0	0	0	6	1
Inspiration Island	0	0	0	0	3	1
Total	7	10	11	11	24	

Current recommendations:
1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.

		2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. 4. Use the staged model of substance abuse training for group facilitators. 5. Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. 6. Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. **Findings:** MSH's Mall course catalog lists groups by level of cognitive functioning. DCAT has conducted cognitive assessments of individuals, and developed a list that was made available to the WRPTs. This monitor reviewed MSH's criteria for determining levels of cognitive functioning. The DCAT members used the criteria to assess and/or categorize 156 individuals for the purpose of assisting WRPTs in assigning individuals to Mall groups. This monitor's review of the Spring 2007 Mall Catalogue showed that the Mall groups identified the stages of change and functioning levels (Advanced, Intermediate, and Challenged) appropriate for individuals registered for the groups. Six groups (Cognitive Computer Training, Cognitive Rehabilitation, and Cognitive Restructuring) were targeted for the Cognitively Challenged level, and one group (GED) was targeted for the Advanced and Intermediate levels; all other groups were considered appropriate for

		"all" cognitive levels. MSH should refine the categories or offer additional groups targeted towards the cognitively challenged individuals. Meanwhile, it is essential that facilitators understand the cognitive levels of individuals in their groups and apply presentations and handouts appropriate to the individual's functioning. **Recommendation 2, March 2007:** Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. **Findings:** According to Swati Roy, Chief of Psychology, unit psychologists are required to complete a cognitive screening for individuals under their caseload, identify the individual's cognitive strengths and weaknesses, and inform the WRPT the individual's level of cognitive functioning (advanced, average, challenged). This monitor reviewed the list of individuals who had their cognitive screening (Program by Unit by Assessment Completed/needed). The list showed that a large numbers of individuals were yet to have their cognitive screening completed. **Current recommendations**: 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the	**Current findings on previous recommendations:**

	Wellness and Recovery Plan review process;	**Recommendation 1-3, March 2007:** • Ensure that all group and individual therapy providers provide the WRPTs with progress report. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. • Use the data from monthly Mall Progress Notes in the WRP review process. **Findings:** MSH has yet to fully implement this recommendation. MSH introduced the progress note requirement for Programs 1 and 2. According to Ken Layman, WRPT members have received training on utilization of information from the Mall progress notes in addressing an individual's progress and including such information in the individual's WRP. An electronic version of the Mall progress note template is available on MSH's network. This monitor reviewed six charts (AF, SG, NH, TS, JE, and HL). Progress notes were found in five of them (AF, SG, NH, TS, and JE) and the notes were integrated into the WRPs, and one of them (HL) did not integrate the Mall provider progress notes into the individual's WRP. **Current recommendations**: 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>C.2.i.viii</td><td>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</td><td>
Current findings on previous recommendations:

Recommendation 1, March 2007:
Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays.

Findings:
MSH provides PSR Mall services, for all five days of the week. However, the hours of the services do not conform to EP requirement. MSH PSR Mall service hours for the various programs are given in the table below. As shown in the table PSR Mall services for Programs 2, 3, and 5 are offered for three hours in the morning and one hour in the afternoon.

<table>
<tr><td>Groups</td><td>Morning hours</td><td>Afternoon hours</td></tr>
<tr><td>Adolescent</td><td></td><td>3:05-4:50PM</td></tr>
<tr><td>SNF(418/419)</td><td>9:30 – 11:30</td><td>1:30 – 3:30</td></tr>
<tr><td>SNF (420)</td><td>9:30 – 11:30</td><td>1:00 – 3:00</td></tr>
<tr><td>Program 1</td><td>10:00-10:50
11:00-11:50</td><td>1:15-2:05
2:05-2:55</td></tr>
<tr><td>Program 2</td><td>09:00-12:00</td><td>3:15-4:05</td></tr>
<tr><td>Programs 3&5</td><td>09:00-12:00</td><td>3:00-4:00</td></tr>
</table>

Recommendation 2, March 2007:
Mandate that all staff at MSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff.
</td></tr>
</table>

Findings:
MSH has yet to implement this recommendation. MSH has not mandated that all staff, other than those who attend to emergency medical needs of individuals be providing services at the PSR Mall, rather, MSH has actively encouraged/mandated that all disciplines provided appropriate hours services at the PSR Malls. The tables below showing the average hours per week scheduled for and served by each discipline for May and June 2007, are summaries of the facility's data.

	May 2007		July 2007			
			Long-Term		Acute	
Position	Sched.	Prov.	Sched.	Prov.	Sched.	Prov.
Staff Psychiatrist	3.2	2.0	3.2	2.2	3.9	2.7
Staff Psychologist	7.3	5.3	9.8	6.8	8.1	5.7
Social Work	7.7	5.7	8.3	5.8	8.3	6.3
RT	12.6	9.0	15.5	11.8	14.2	9.8
RN	2.5	1.4	x	X	2.5	1.7
PT, LVN, PTA/PLPT	3.0	1.7	x	X	2.6	1.7
SPT	1.6	1.1	x	X	1.6	1.0
US/SRN	1.5	1.1	x	X	1.3	1.0

	May 2007		July 2007	
Position	Sched.	Prov.	Sched.	Prov.
ADM	1.6	1.0	2.1	1.5
CNS	1.9	1.4	1.1	0.8
Dietary	2.0	1.1	2	1.3
HPD	1.2	0.9	1.2	0.9
Pharm	0.6	0.4	0.8	0.4

Prog ADM	2.1	1.4	1.6	1.1
Standards C	0.9	0.6	1.5	0.9
D-CAT/PBS	1.4	1.0	1.4	1.0
Med Serv	1.1	0.8	0.0	0.0
Psych Inter	6.3	5.2	X	X
CPS	1.9	1.4	19.9	14.2
Plant Op	13.6	5.9	6.8	3.0
Sr. Psychiatrist	1.0	0.6	2.0	0.1

MSH has noted increase in staff participation in PSR Mall services through administrative directive and encouragement. According to Ken Layman, the increase happened despite 15 staff vacancies since May 2007.

Recommendation 3-4, March 2007:

3. Provide groups as needed by the individuals and written in the individuals' WRPs.
4. Add new groups as the needs are identified in new/revised WRPs.

Findings:

According to Ken Layman, WRPTs have been trained to engage individuals in selecting groups from the Mall catalog that align with their objectives, and to get the Mall coordinators support to add new Mall groups. MSH has added a total of eleven new groups since the last review.

Current recommendations:

1. Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on

		State holidays. 2. Mandate that all staff at MSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff. 3. Provide groups as needed by the individuals and written in the individuals' WRPs. 4. Add new groups as the needs are identified in new/revised WRPs.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Implement the curriculum for bed-bound individuals. **Findings:** MSH has developed and implemented Mall curriculum for bed-bound individuals. This monitor reviewed the bed-bound Mall curriculum. The curriculum included the activity, description of the activity, the skill level, and the benefit of the activity. The list of activity is varied (for example, pet therapy, gardening, relaxation, exercise, social time, and Wellness and Recovery). This monitor reviewed the documentation and visited the bed-bound units (418, 419, and 420). Mall schedules were posted by the individual's bedside and activity lists were posted on the walls. A spreadsheet was posted on the wall indicating the days, dates, and activities conducted. Providers signed off on the activity list daily after providing the services as per the schedule. **Current recommendation**: Continue with the implementation of the curriculum for bed-bound individuals.

C.2.i.x routinely takes place as scheduled;

Current findings on previous recommendations:

Recommendation 1-2, March 2007:

1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.
2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

Findings:

MSH has established regular weekly meetings of Program managers to address implementation of Mall groups. MSH has also introduced a system to include cognitive levels of individuals in the Mall schedule spreadsheets. Curriculum for bed-bound individuals has been implemented. DCAT members continue to identify cognitive levels of individuals and make the information available to Mall facilitators.

The tables below showing the Mall groups conducted (reporting a mean range of 87% to 96% conducted as scheduled), and the number of Mall groups cancelled per month (reporting a mean range between 2 to 48 groups cancelled per Mall area) are summaries of the facility's data.

Percentage of Mall groups conducted as per schedule from March 2007 to July 2007

Malls	Mar	Apr	May	Jun	Jul	Mean
Discov Bay	96	90	92	100	100	96
DB 404	93	97	96	99	97	96
Outward Bound	71	96	95	92	96	90
Bridge to Recovery	86	95	95	96	96	94
New Horizon	78	86	92	96	96	90
Inspiration Island	75	88	88	89	97	87

Number of groups cancelled per month from March 2007 to July 2007

Mall	Mar	Apr	May	Jun	Jul	Mean
Discov Bay	6	12	9	0	0	5
DB 404	X	3	5	1	0	2
Outward Bound	48	10	9	10	0	15
Bridge to Recovery	91	70	47	28	2	48
New Horizon	52	64	22	13	0	30
Inspiration Island	46	12	29	16	1	21

Recommendation 3, March 2007:
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
The leadership at MSH has taken administrative steps to encourage staff to provide services at PSR Mall groups. The table below showing the disciplines, the number of hours scheduled, the number of hours served by each discipline is a summary of the facility's data.

	May 2007		July 2007			
			Long-Term		Acute	
Position	Sched.	Prov.	Sched.	Prov.	Sched.	Prov.
Staff Psychiatrist	3.2	2.0	3.2	2.2	3.9	2.7
Staff Psychologist	7.3	5.3	9.8	6.8	8.1	5.7
Social Work	7.7	5.7	8.3	5.8	8.3	6.3
RT	12.6	9.0	15.5	11.8	14.2	9.8
RN	2.5	1.4	x	X	2.5	1.7
PT, LVN, PTA/PLPT	3.0	1.7	x	X	2.6	1.7
SPT	1.6	1.1	x	X	1.6	1.0

US/SRN	1.5	1.1	x	X	1.3	1.0

As shown in the table above, none of the disciplines consistently meet the required hours of service. According to Ken Layman, most disciplines have increased their hours of service as a result of administrative oversight and supervision. He expects the hours of service to further increase when a number of vacancies at MSH are filled.

Recommendation 4, March 2007:
Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:
MSH is taking steps to ensure that administrators and support staff facilitate a minimum of one Mall group per week. The table below showing the disciplines, and the average number of hours scheduled and served by these disciplines is a summary of the facility's data.

	May 2007		July 2007	
Position	Sched.	Prov.	Sched.	Prov.
ADM	1.6	1.0	2.1	1.5
CNS	1.9	1.4	1.1	0.8
Dietary	2.0	1.1	2	1.3
HPD	1.2	0.9	1.2	0.9
Pharm	0.6	0.4	0.8	0.4
Prog ADM	2.1	1.4	1.6	1.1
Standards C	0.9	0.6	1.5	0.9
D-CAT/PBS	1.4	1.0	1.4	1.0
Med Serv	1.1	0.8	0.0	0.0

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<tr><td>Psych Inter</td><td>6.3</td><td>5.2</td><td>X</td><td>X</td></tr>
<tr><td>CPS</td><td>1.9</td><td>1.4</td><td>19.9</td><td>14.2</td></tr>
<tr><td>Plant Op</td><td>13.6</td><td>5.9</td><td>6.8</td><td>3.0</td></tr>
<tr><td>Sr. Psychiatrist</td><td>1.0</td><td>0.6</td><td>2.0</td><td>0.1</td></tr>
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As the table above shows, a number of disciplines (administration, dietary, Program Administrators, D-CAT/PBS, Plant Op, interns, and CPS) are meeting criteria. The interns are completing their internship in July showing no hours posted for the month of July). According to Ken Layman, there was a loss of 15 support staff during the month of July, leaving 83 staff to provide group services. Also, the Executive Director is reported to have reviewed the data and followed up with the department managers to ensure that the staff meet this recommendation.

Current recommendations:
1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.
2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.
3. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.
4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
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<td>C.2.i.xi</td>
<td>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that</td>
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act as a barrier for individuals to participate in such activities.

Findings:
MSH has assigned Program Directors to oversee the provision of opportunities for individuals to participate in enrichment activities in the evenings and weekends, and to eliminate/reduce competing activities that may act as barriers to participation. Furthermore, staff has attended Basic Group Leadership training during which time they were asked to review the content and schedules of these activities and to work with individual representatives to ensure that appropriate groups were available.

Recommendation 2, March 2007:
Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

Findings:
MSH has had its Program Directors develop a tracking system to capture the hours of enrichment activities provided to individuals in the evenings and weekends. The table below showing the hours of activities provided by programs for the months of February and July 2007 is a summary of the facility's data.

Average Hours of Scheduled Supplemental Activities Per Week.

Program	Feb 07	Jul 07
Program I	28	33
Program II	26	35
Program III	20	20
Program V	22	22
Program VI	18	18

The table shows an increase in the hours of activities scheduled from

		February 2007 and July 2007 for Programs I and II, while all the other Programs maintained their hours. According to Ken Layman, the enrichment database was to be upgraded in WaRMSS for better accounting of the hours and types of activities provided on weekends and evenings. MSH should continue to increase the hours offered in Programs I and II, as well as the other Programs. Furthermore, oversight may serve well to evaluate the actual quality of services provided. **Current recommendations**: 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** MSH used item #12 of the DMH WRP Chart Audit to address this recommendation reporting a mean compliance of 7%. The table below with its monitoring indicator showing the number of WRPs by month from March to July 2007 (N), the number of WRPs audited by chart review (n), and the compliance obtained (%C), is a summary of the facility's data

Adequate psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including the living units.

	Mar	Apr	May	Jun	Jul	Mean
N	653	674	810	683	659	
N	101	144	116	93	79	
%S	15	21	14	14	12	
%C -#12	13	9	6	2	6	7

This monitor reviewed 10 charts (CG, RV, KM, DM, FR, MF, RR, LA, CK, and PW). Except for one (DM), the others (CG, RV, KM, FR, MF, RR, LA, CK, and PW) did not identify the therapeutic milieu in one or more of the interventions in the individuals' WRPs.

Recommendation 2, March 2007:
Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.

Findings:
MSH used item #12 of the Therapeutic Milieu Observation Monitoring Form to address this recommendation, reporting a mean of 47% compliance. MSH collected data by conducting unit milieu observations for 30 minutes at each unit during various times and days. The table below with its monitoring indicator showing the number of living units (N), the number of units observed (n), and compliance obtained (%C) is a summary of the facility's data.

Staff is observed discussing Mall activities with individuals.

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<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>18</td><td>18</td><td>18</td><td>18</td><td>18</td><td></td></tr>
<tr><td>N</td><td>10</td><td>10</td><td>10</td><td>10</td><td>10</td><td></td></tr>
<tr><td>%S</td><td>56</td><td>56</td><td>56</td><td>56</td><td>56</td><td></td></tr>
<tr><td>%C - #12</td><td>40</td><td>30</td><td>50</td><td>x</td><td>67</td><td>47</td></tr>
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According to Ken Layman, Nursing staff has been trained on this recommendation during the Nursing Annual Update (NAU) activity, so that the staff know the Milieu class "All Staff Know Individual's Objectives and Reinforce Mall Learning."

This monitor's observation showed that individuals received regular verbal/social reinforcement from staff at PSR Mall groups and WRPCs.

Current recommendations:
1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.
2. Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.
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<td>C.2.j</td>
<td>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Establish group exercises and recreational activities for all individuals.

Findings:
MSH has established a curriculum committee for each Mall for the purpose of designing and implementing groups as required for each individual. In addition, Mall Coordinators and Program Managers are using Mall Needs Assessment information for offering group exercise and recreation. The table below outlining the number of recreational</td>
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and exercise groups offered each month in each Mall area is a summary of the facility's data.

	Mar	Apr	May	Jun	Jul	Mean
Disc Bay	4	7	7	7	6	6
DB 404	5	13	13	13	11	11
Outward B	9	8	8	8	6	8
Bridge Recovery	34	75	75	75	74	67
New Horizon	21	42	41	41	30	35
Inspiration Island	10	17	17	17	17	16

MSH reviewed participation of individuals with high BMIs in exercise and recreational activities. The table below showing the number of individuals within each BMI category (N), the number of individuals reviewed within each category (n), and the mean percent participation of these individuals in the recreational activities and/ or exercise programs (%C) for the month of July, is a summary of the facility's data.

BMI LEVEL	July
BMI change <25 to 25 — 29.9	N= 196 n= 31 %S= 16 %C= 63
Body Mass Index (BMI) between 30 and 34.5 (Obesity-Grade I)	N=117 n= 20 %S= 17 %C= 75
Body Mass Index (BMI) between 35 and 39.9 (Obesity-Grade II)	N= 40 n= 8 %S= 20 %C= 61

		<table><tr><td>Body Mass Index (BMI) of 40 or above (Obesity-Grade III)</td><td>N= 20 n= 16 %S= 80 %C= 52</td></tr></table> As shown in the table above, participation of individuals with high BMIs in recreational activities and exercise ranges between 52% and 75%. MSH should increase the participation of these individuals in a variety of recreational activities and exercises. Furthermore, data should be analyzed for more than one month to evaluate stability of the individuals' participation in recreational activities and exercise across time. This monitor reviewed MSH's Resource List. MSH's resources are abundant in most of the areas (Focus 1 -11, Staff Education, Enhancement/Leisure, and supplemental material). However, the resource for "exercise" is lean. MSH should increase the available resources for exercise related information. . **Recommendation 2, March 2007:** Provide training to Mall facilitators to conduct the activities appropriately. **Findings:** MSH is providing competency-based training to Mall facilitators on conducting activities. In June 2007, MSH trained 102 staff from various disciplines (Medicine, Psychology, Social Work, Rehabilitation, and Nursing) on "Basic Group Leadership", with 75 of the staff achieving scores of 80% and over. **Recommendation 3, March 2007:** Track and review participation of individuals in scheduled group exercise and recreational activities.

		Findings: According to Ken Layman, Mall Directors review the MAPP program to track participation of individuals in exercise and recreational activities. The Mall Directors share the information with the program managers. MSH tracked and reviewed participation in recreational activities and exercise only among individuals with high BMIs (see table in Recommendation 2 above). MSH should audit participation of all individuals in recreational activities and exercise. **Recommendation 4, March 2007:** Implement corrective action if participation is low. **Findings:** MSH has not reviewed participation levels of all individuals in the facility to identify those with low levels of participation and take corrective action. **Compliance:** Partial. **Current recommendations**: 1. Establish group exercises and recreational activities for all individuals. 2. Provide training to Mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with	**Current findings on previous recommendations:**

	generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Recommendation 1-2, March 2007:** 1. Conduct a needs assessment with individuals and/or their families. 2. Ensure that family therapy needs are fulfilled. **Findings:** According to the Chief of Social Work, a needs assessment for family therapy services was conducted. However, no data was made available for review. **Compliance:** Partial. **Current recommendations:** 1. Conduct a needs assessment with individuals and/or their families. 2. Ensure that family therapy needs are fulfilled.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** Regarding the elements of this requirement, MSH developed the Medical Conditions Monitoring instrument and instructions addressing the individual's WRP. The table below summarizes MSH's compliance data regarding each item from the EP. N= Total number of WRPs due for the month n= Number of Nursing Medical Conditions Focus 6 Audits completed for the month

	Mar	Apr	May	Jun	Jul	Aug	Mean
Medical Conditions Monitoring Form							
N	653	674	810	683	659		696
n	29	21	196	146	161		111
%S	4	3	24	21	24		15
Compliance rates:							
#1: Each of the open medical conditions listed on the Medical Conditions list are identified in the WRP under Focus 6.	90	100	63	62	52		73
#2: Does the WRP identify the general medical diagnosis?	76	91	87	86	86		85
#3: Does the WRP identify the treatment to be employed for this condition?	72	67	77	76	76		74
#4: Does the WRP identify the related symptoms to be monitored by nursing staff?	52	67	58	46	46		54
#5: Does the WRP identify by what means staff will monitor these symptoms?	62	48	63	48	58		56
#6: Does the WRP identify by what frequency staff will monitor these symptoms?	59	43	44	21	40		41
#7: Staff to perform	62	33	57	35	26		43

		these interventions are identified by title? | | | | | | | | From my review of 30 individuals' WRPs (CJ, JM, DW, RR, JB, SH, CK, LO, ES, JG, SG, JP, TC, DM, TM, RO, JJ, IC, ME, PL, MM, MB, AE, JU, FK, GK, JE, SV, KA, HQ), I found that overall, the medical diagnoses were identified and most of the WRPs addressed the open medical conditions in Focus 6. However, the areas regarding specific monitoring of symptoms, frequency, and assigned staff identified were consistently missing in the WRPs for all 30 reviewed. My findings were similar to those of MSH. In addition, I found little documented evidence in the progress notes that interventions were actually implemented. For example, a number of interventions included providing education to the individual. However, I could not find documentation indicating that this was being provided. From my discussion with Nursing, these areas are in need of significant improvement. **Compliance:** Partial. **Current recommendations:** 1. Provide training regarding the elements of this requirement. 2. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that children and adolescents with traumatic family and other

traumatic experiences receive appropriate and timely assessment and treatment services.

Findings:
MSH has tracked adolescents with traumatic family and other traumatic experiences and attempted to conduct assessments and provide treatment services. The table below indicating if individuals with trauma have received assessments, and if they and their families are receiving treatment services, is a summary of the facility's data.

Initials	Assess of Trauma?	Hx of trauma	Family Treatment	Individual Therapy
AC	Yes	Yes	No	Yes
EC	Yes	Yes	No	Yes
RD	Yes	Yes	No	Yes
PD	Yes	Yes	No	Yes
RF	Yes	Yes	No	Yes
JL	Yes	Yes	No	Yes
SM	Yes	Yes	No	Yes
JM	Yes	Yes	No	n/a
CG	Yes	Yes	No- family abuse	Yes
EH	Yes	Yes	No- no contact	Yes
RM(MSH# 261199-4)	Yes	Yes	No- deceased	Yes
RM(MSH# 261344-6	Yes	Yes	No	Yes

As data in the table above shows, MSH conducted assessments on all individuals identified as having experienced trauma and individual/group therapy is being provided to all of them, however, family treatment is not being conducted on any of these cases. According to Ken Layman,

		MSH family treatment was not possible for this group of individuals due to lack of family involvement and/or unwillingness on their part to participate in services offered. **Current recommendations**: Ensure that children and adolescents with traumatic family and other traumatic experiences receive appropriate and timely assessment and treatment services.
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	**Current findings on previous recommendations:** **Recommendation 1-4, March 2007:** 1. Continue to monitor children and families' needs. 2. Communicate relevant information to appropriate persons and the WRPT. 3. Actively expand the opportunities for these individuals and their families to receive appropriate services. 4. Collect outcome and satisfaction data. **Findings:** MSH's adolescent program actively seeks input from family members of children and adolescents. MSH has edited item #4 of the DMH 30-Day Assessment to include this recommendation. According to the Chief of Social Work, MSH received three Family Satisfaction Surveys from families, reporting satisfaction with MSH's response to their needs. According to the Chief of Social Work, staffing issues have made it difficult to expand the program at this time. **Current recommendations**: 1. Continue to monitor children and families' needs. 2. Communicate relevant information to appropriate persons and the WRPT.

		3. Actively expand the opportunities for these individuals and their families to receive appropriate services. 4. Collect outcome and satisfaction data.
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Finalize and implement the policy and procedure. **Findings:** The facility has finalized and implemented AD 3415, Screening Individuals for Substance Abuse, in June 2007. Staff received training on the new policy in June 26 and 28, 2007. **Compliance:** Partial. **Current recommendations:** Monitor the implementation of the policy and procedure to ensure correction of the deficiencies identified in C.2.o below.
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** The substance recovery (SR) program should utilize clinical outcomes for individuals and process outcomes for the program. **Findings:** MSH has revised its list of clinical and process outcomes to ensure that indicators of outcome are better delineated and that the clinical outcomes are based on learning and behavioral measures. Examples of clinical outcomes include the following areas:

		1. Upward movement along the stages of change as evidenced by self-assessment questionnaires administered at the beginning and end of each SR group. 2. Increased interest in and awareness of personal recovery as evidenced by responses to specific post-test questions. 3. Demonstration of goal-setting behaviors as evidenced by responses to specific post-test questions. The process outcomes list includes the following examples: 1. Number of individuals screened for substance abuse per month 2. Number of individuals with positive screens who have received substance abuse assessment as evidenced by chart audits. 3. Number of individuals with substance abuse who have received at least one objective and one intervention that are linked to their stage of change. 4. The number of WRPs that have updated information that is derived from the monthly Mall progress notes as evidenced by chart audits. 5. The number of SR providers trained to competency 6. The number of SR groups provided. 7. The number of SR groups provided in Spanish (for monolingual individuals). 8. The percent of groups categorized by stage of change and cognitive level. The above examples are appropriate measures of clinical and process outcomes. However, some indicators listed as clinical outcomes address the level of attendance and participation of individuals in SR groups, validation of the individuals' stages of change and the tracking and documentation of this level in the monthly Mall progress notes. These indicators are more appropriate as process outcomes. MSH has selected pre-/post- testing formats to be used in the

measurement of clinical outcomes. Providers have been trained and are currently providing pre-test results to the WRPTs via progress notes for review of progress and to the SR Coordinator for data entry and analysis. The Substance Recovery Committee reportedly reviews the data as well. MSH presented some data regarding Pre-test results for individuals participating in SR groups. However, the data appear to be incomplete and are not accompanied by an explanation of the context (e.g. total target population, population reviewed and sample size).

Recommendation 2, March 2007:
Implement the DMH Clinical Chart Auditing Form to monitor this requirement, including the correct identification of the stages of change.

Findings:
MSH has implemented this recommendation. The data presented by the facility are based on the following two processes:

The Clinical Chart Auditing Form (June and July):
The data are based on an average sample of 5%. The following is an outline of the monitoring indicators and corresponding mean compliance rates:

1.	*Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services*	56%
2.	*Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues*	4%

			particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care	

The criteria for item #1 in the tool's instructions includes "When substance abuse is identified on Axis I, it is written Focus 5, and has at least one objective with an appropriately linked intervention." MSH reported that improvements in this area are a result of WRP training and Substance Recovery training that occurred during the period. However, the criteria for item #2 involved the alignment between the groups, stages of change, and the needs indicated in the case formulation. In this area, the facility recognized that much more work is needed to improve compliance.

The Substance Recovery Assessment and Treatment Recovery Auditing Form (May to July 2007): The average sample size was 4% of the estimated number (N) of individuals diagnosed with substance use disorders. The indicators used are well-aligned with requirements with the EP. The following is an outline of the mean compliance rates and corresponding indicators:

1.	*If there is a positive screening for substance abuse, is there an Axis I substance abuse diagnosis that is consistent with DSM-IV-TR criteria and the case formulation*	18%
2.	*The case formulation includes a summary of assessment findings*	0%
3.	*The precipitating, predisposing, and/or perpetuating factors indicate the individual's vulnerability to relapse*	2%
4.	*The precipitating, predisposing, and/or perpetuating factors indicate the interaction between substance use/abuse and other mental illness diagnoses*	4%

		5.	*The precipitating, predisposing, and/or perpetuating factors indicate the relationship, if any, between substance use/abuse and forensic charges*	3%
		6.	*The stage of change is identified in the present status section of the case formulation*	1%
		7.	*The SA objectives consistent with the individual's stage of change*	2%
		8.	*The SA objectives achievable, measurable, and easy to understand*	10%
		9.	*The SA interventions consistent with the individual's stage of change*	3%
		10.	*The SA interventions consistent with the individual's level of cognitive functioning*	5%
		11.	*The (SA) intervention(s) provide the means for the individual to achieve the objective*	11%
		12.	*Mall progress notes document the individual's progress in substance abuse treatment groups (at least one note per month must be present)*	4%
		13.	*The WRP has been updated based on information from the progress notes*	4%
		In addition, the facility reported data based on the Chart Auditing Form (March to July 2007). However, these data are discounted because the total target population (N) was inaccurately calculated and the indicator used did not address linkage to the stage of change. This process should have been eliminated in lieu of the Clinical Chart Auditing Form. **Recommendation 3, March 2007:** Finalize and implement the training curriculum to include the maintenance phase of change.		

		Findings: MSH has adopted NSH's training curriculum regarding the maintenance phase. In addition, the facility presented documents related to the implementation of this recommendation. This monitor's review of these documents indicated the following: 1. The SR program has initiated a training program to improve the competency of SR providers in the following domains: a. Trans-theoretical model and stages of change; b. Professional and ethical responsibilities; c. Clinical evaluation; d. Referrals; e. Treatment planning; f. Documentation; g. Counseling skills; h. Motivational Enhancement; i. Dual-diagnosis issues; j. Drugs and addiction; k. Special populations (adolescents, women, elderly, forensic and cognitively impaired); l. Service coordination; m. Relationships and family dynamics; n. Addiction and forensic issues; o. The process of relapse and relapse prevention; and p. Recovery process (support and wellness). The above domains include competency criteria based on the publication "Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice," by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, these domains reportedly include additional material to ensure alignment with the facility's stage-specific manuals, the needs of the specific population at MSH and the publication "Enhancing Motivation for

		Change In-service Training" by SAMHSA. The facility presented an outline of the training domain pertaining to Clinical Evaluation, a lesson plan related to the pre-contemplative to contemplative stage and a course overview regarding the preparation/action stage. The SR coordinator indicated that this program is intended to ensure competency of those providers who have not completed substance abuse certification programs in the community. In addition, the facility' presented Lesson Plan Formats for Treatment Enhancement Staff Education and Training Sessions. This material addresses training of SR providers that appears to be provided by the Treatment Enhancement Department. The training involves the following eight modules: 1. Introduction; 2. Conceptualizing motivation and change; 3. Motivation and intervention; 4. Basic strategies of motivational enhancement; 5. Motivational interviewing as a counseling style; 6. From pre-contemplation to contemplation-building readiness; 7. From contemplation to preparation-increasing commitment; 8. From preparation to action-getting started. The above-mentioned training programs appear to be based on current literature and aligned with the trans-theoretical model. However, MSH's report of its training programs lacks a coordinated approach to ensure that it is clear who trains who and for what purpose, that the materials in the current manuals are utilized in all programs, and that the methods and purposes of training are guided by a clear strategy throughout the facility.

		Recommendation 4, March 2007: Ensure monitoring of a 20% sample of the target population. **Findings:** The facility has yet to implement this recommendation. **Other findings:** This monitor reviewed the charts of five individuals diagnosed with substance use disorders (FJK, DRM, JC, JRA and MAH). All charts included substance abuse as a diagnosis, with a corresponding focus. Only three charts included corresponding objectives and interventions (DRM, JRA and MAH). No chart included objectives and interventions that were linked to appropriate stages of change. **Compliance:** Partial. **Current recommendations**: 1. Strengthen administrative oversight to the SR program. 2. Refine process and clinical outcomes to correct deficiencies identified above. 3. Provide pre- and post-testing to assess learning of individuals in all SR programs. 4. Provide documentation of all current training programs of SR. The data must: a) Provide an outline of each program; b) Identify who is training who and for what purpose; c) Explain how all programs are aligned with the facility's current stage-specific training manuals, and the two publications by SAMHSA; and d) Document results of competency-based training of SR providers and link the results with the programs provided. 5. Monitor this requirement using the Clinical Chart Auditing Form

		(not the Chart Auditing Form) and the Substance Recovery Assessment and Treatment Recovery Auditing Form, based on at least a 20% sample of the total number of individuals diagnosed with substance use disorders.
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Monitor the competency of group facilitators and therapists in providing rehabilitation services. **Findings:** MSH reported on the competency of the Substance Abuse Facilitators and Rehabilitation Therapists (March to July, 2007), and Program I Facilitators (April to July 2007). However, the data presented by the facility lacked specificity and are thus not included in this report. **Compliance:** Partial. **Current recommendation**: Monitor the competency of group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum.

Findings:
MSH reviewed the training records for the PSR Mall Substance Recovery Training from March to July 2007. The facility reported that a total of 71 staff members were trained during this period and that training continues monthly for providers and potential providers. An overall competency rate of 85% was reported for that period. However, the facility did not specify the target population, the type of training provided and the measures of competency. The following is an outline of the dates of training, the number of staff trained and the number of staff who met the facility's competency standard.

Date of training	Number of staff trained	Number of staff who met competency measure
3/27/07	16	13
4/3/07 & 4/24/07	25	23
6/6/07 & 6/27/07	17	15
7/11/07	13	12

Recommendation 2, March 2007:
Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.

Findings:
This monitor reviewed MSH's Substance Abuse Curriculum and Substance Recovery Certification Program and noted that the competency criterion is aligned with the training curriculum. MSH's substance abuse recovery is also said to be aligned with other accreditation and training bodies including the Trans-Theoretical Model and the Substance Abuse Mental Illness Services Association.

Recommendation 3, March 2007:
Ensure that training includes all of the five stages of change.

		Findings: According to Ken Layman, MSH has acquired the Substance Recovery Curriculum for all five stages. However, current training is at the first and second stages. **Recommendation 4, March 2007:** Establish a review system to evaluate the quality of services provided by these trained facilitators. **Findings:** MSH has set up a system to review 20% of the facilitators to evaluate the quality of services provided in Mall groups. In addition, MSH has also scheduled monthly supervision with Dr. Hernandez. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1-3, March 2007:** 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Assess why individuals refuse medical appointments and find ways

to resolve their concerns.

3. Complete and implement the Medical Scheduler.

Findings:

MSH reviewed the number of appointments missed and the reasons for the missed appointment. The table below showing the number of appointments scheduled for each month (N) from March through July 2007, the number of appointments completed (n), the percentage of appointment completed (reporting 79% completion on average), and the percentage of missed appointments for various reasons (refusals, individual unavailable, and Staffing) is a summary of the facility's data.

	Mar	Apr	May	Jun	Jul	Mean
N	1654	1679	1489	1196	1273	
n	1288	1332	1195	951	989	
%C	78	79	80	80	78	79
%C, refused	89	91	93	94	89	91
%C: Individual not available	3	8	1	3	5	4
%C: Staffing	0	0	0	0	0	0

As the data in the table shows, over 90% of the missed appointments were due to the individuals refusing to attend their scheduled appointments. There is no understanding as to why these individuals refused to complete their scheduled appointments. However, MSH has taken steps to reduce the number of missed appointments including the use of shackles to transport individuals to their appointments. This monitor witnessed an individual being placed in shackles prior to being transported to an appointment. The individual was passive/cooperative during the process and got into the van without any obvious distress or struggle. Other actions taken to reduce missed appointments include:

1. Medical Service informs Unit Supervisors and Nursing Coordinators

		when an individual misses three scheduled appointment. The WRP then addresses this issue with the individual. 2. Sign incentive point cards at the clinic. 3. Developed a spreadsheet database to track and monitor appoints scheduled and missed. MSH has not implemented the Medical Scheduler. According to Ken Layman, there are flaws in the system that has to be corrected before the Medical Scheduler can be implemented. **Compliance:** Partial. **Current recommendations**: 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Assess why individuals refuse medical appointments and find ways to resolve their concerns. 3. Complete and implement the Medical Scheduler.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. **Findings:** MSH is training staff on procedures and considerations to be included when assigning individuals to groups. MSH used item #10 from the DMH WRP Clinical Chart Audit to address this recommendation, reporting 4% compliance. The table below with its monitoring indicator showing the number of WRPs for each month (N), the number of WRPs audited through chart reviews (n), and the percentage compliance

obtained (%C) is a summary of the facility's data.

Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.

	Jun	Jul	Mean
N	521	465	
n	4	34	
%S	1	7	
%C -#10	0	6	4

As the data in the table above show, utilization of an individual's cognitive levels, needs, and strengths are rarely practiced when individuals are assigned to groups. According to Ken Layman, further training and mentoring of WRPTs is to be conducted to ensure that they attend to this recommendation when assigning groups to individuals.

Psychologists are required to conduct cognitive screening of all individuals and the DCAT is also conducting cognitive screening with individuals suspected to have experienced changes in cognition. These information should be used by WRPTs to compare the cognitive levels of individuals against the cognitive levels indicated for PSR activities (as identified in the Mall Catalogue) when assigning individuals to PSR Mall groups.

This monitor reviewed seven charts (KM, PW, MF, CG, DM, FR, and CK).

		Only three of them (CK, FR, and PW) identified the individual's strengths, interests, and preferences in their interventions. The remaining four (DM, CG, RV, and KM) did not consistently identify the individual's strengths, interest, and preferences. **Recommendation 2, March 2007:** Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. **Findings:** MSH has included Group Facilitation as an item in new employee orientation. MSH also conducted seven training sessions on group facilitation to 143 staff. **Recommendation 3, March 2007:** Develop and implement monitoring systems that address all of the required elements. **Findings:** MSH has decided to use the Facilitator Monitoring Form, Substance Recovery Assessment and Treatment Auditing Form, and DMH Clinical Chart Audit as a means of monitoring facilitator competency in Mall groups. **Compliance:** Partial. **Current recommendations:** 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals'

		needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendation 1-3, March 2007:** 1. Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. 3. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. **Findings:** MSH has finalized and submitted for approval the WRP/MALL Protocol Monitoring Tool to ensure the process outcomes of treatment and/or rehabilitation services, and tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. MSH used item #11 from the DMH WRP Chart Audit Form, reporting 5% compliance. The table below with its monitoring indicator showing the number of monthly, quarterly, and annual WRPs per month (N) for the months of June and July 2007, the number of Charts audited (n), and the percentage of compliance (%C) is a summary of the facility's data. *Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof.*

	Jun	Jul	Mean
N	521	465	
n	4	34	
%S	1	7	
%C -#11	0	6	5

As shown in the table above, PSR Mall service outcome data are not regularly documented, data reported, or timely revisions made according to the individual's progress or lack thereof.

This monitor reviewed ten charts (GD, NH, LR, BB, SFY, GG, JT, SW, SH, and JM). None of them included all the elements required for this recommendation. Generally, the groups and individual therapies were linked to the foci, objective and/or interventions, but the objectives were not observable/ measurable. In addition, Mall progress notes were not available for each active treatment. None of them used data to revise the objective or offered any clinically justifiable reason for continuing with the objective. For example, objective for BB reads, "Mr. B. will learn skills to adapt to the community living upon discharge to CONREP" this objective did not explain the type of skills or the nature of the community BB was expected to be living in.

Compliance:
Partial.

Current recommendations:
1. Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.
2. Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services.
3. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and

<table>
<tr><td></td><td></td><td>interventions specified in the WRP.</td></tr>
<tr><td>C.2.u</td><td>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Ensure that the Mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities.

Findings:
MSH reported that each Mall has an active curriculum committee whose role is to design and implement required Mall curriculum. Mall Coordinators and Program Managers use needs assessment information gathered during the last review to make adjustments to the Mall offerings.

Recommendation 2, March 2007:
Increase the number of Mall groups that are provided to address this requirement.

Recommendation 3, March 2007:
Develop and implement a monitoring tool to address this requirement.

Findings:
MSH has monitored the number of groups teaching about the purpose of treatment, rehabilitation and enrichment per Mall. The following table illustrates the mean number of groups provided in each Mall (March to July 2007).

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>Discovery Bay</td><td>3</td><td>2</td><td>2</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>DB 404</td><td>3</td><td>2</td><td>2</td><td>2</td><td>1</td><td>2</td></tr>
<tr><td>Outward Bound</td><td>1</td><td>1</td><td>1</td><td>1</td><td>3</td><td>1</td></tr>
</table>
</td></tr>
</table>

Bridge to Recovery	0	6	6	6	3	5
New Horizon	5	10	10	10	4	9
Inspiration Island	3	6	6	6	6	5
Total	15	27	27	27	19	24

The table shows that number of these groups has increased from 15 in March 2007 to 27 in May 2007. However, this number dropped to 19 in July 2007. The facility reported that the Mall Director is working with the program managers and Mall curriculum committees to increase the number of these groups.

Recommendation 4, March 2007:
Ensure that individuals are provided copies of their WRPs based on clinical judgment.

Findings:
MSH has monitored implementation of this requirement. The facility reported a mean compliance rate of 39% based on an average sample of 7% of the total number of WRPs due each month (March to July 2007). The compliance rate was noticeably higher in the month of July (62%), which was attributed to improved administrative oversight. MSH reported that this requirement is discussed during the Engagement Module of the training and tracked in the WRP Observation Monitoring process.

Compliance:
Partial.

Current recommendations:
1. Increase the number of Mall groups that are provided to address this requirement, based on needs assessment.
2. Provide data to identify number of groups and discipline of providers.

		3. Continue to monitor implementation of this requirement, and ensure at least a 20% sample size.
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Increase the number of Mall groups that offer education regarding medication management. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** Review of the facility's MAPP data showed that the average number of groups provided during the period of March to July 2007 was 61. This represents an increase of about 17 groups from the previous review period. The providers are psychiatrists, nursing and pharmacy staff. As mentioned earlier, each Mall has an active curriculum committee in order to design and implement medications management groups. The Mall Coordinators and Program Managers use needs assessment information gathered during the last review to modify Mall offerings. **Compliance:** Partial. **Current recommendations:** 1. Increase the number of Mall groups that are provided to address this requirement, based on needs assessment. 2. Provide data to identify number of groups and discipline of providers.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's	**Current findings on previous recommendations:**

	barriers to participation in therapeutic and rehabilitation services.	**Recommendation 1, March 2007:** Continue implementation of mechanisms to track non-adherence to WRPs. **Findings:** The facility has implemented this recommendation. During the period of March to July 2007, 345 individuals, approximately 50% of the census, reached the trigger for non-adherence to WRP for more than 20% of the time in seven consecutive days (adults) and non-attendance at school for more than 20% of the interventions in seven consecutive days (children and adolescents). The facility has developed a form to be used by the teams to address trigger notifications for non-adherence and to report corrective actions taken. **Recommendation 2, March 2007:** Assess barriers to individuals' participation in their WRPs. **Findings:** MSH reported that the WRPTs have been directed to ask the individual during the WRPCs if he/she is able to understand the materials presented in the PSR Mall groups or individual therapy. The facility has yet to assess other barriers to participation in the WRPs. **Recommendation 3, March 2007:** Provide training to the WRPTs to ensure implementation of: a) Appropriate individual therapy to individuals' non-adherence to WRP in the Key Indicator; and b) Clinical strategies to help individuals achieve readiness to engage in group activities. **Findings:** This training is reportedly scheduled for September 2007.

		Recommendation 4, March 2007: Implement tools to assess compliance with this requirement. **Findings:** Same as in Findings under Recommendation 1. **Compliance:** Partial. **Current recommendations**: 1. Track non-adherence to WRPs and WRPTs' responses to notifications. 2. Assess other barriers to individuals' participation in their WRPs and provide corrective actions to all identified barriers. 3. Provide training to the WRPTs to ensure implementation of: a. Appropriate individual therapy to individuals non-adherence to WRP in the Key Indicator; and b. Clinical strategies to help individuals achieve readiness to engage in group activities.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress:** **<u>Psychiatric Assessments and Diagnoses</u>** 1. MSH has implemented the new Physician Quality Profile. 2. MSH has improved documentation of the neurological examination, as part of the admission physical examination. 3. MSH has facilitated training to its psychiatry staff regarding the cognitive/neuropsychiatric aspects of mental illness. The training was provided by university-affiliated instructors. 4. In general, MSH has maintained progress in the finalization of psychiatric diagnoses listed as not otherwise specified (NOS). 5. In general, the facility has maintained its practice of timely implementation of the admission medical and psychiatric assessments, integrated psychiatric assessments, psychiatric reassessments on the long-term units and the transfer assessments. **<u>Psychological Assessments</u>:** 1. MSH has made progress in the development and implementation of monitoring tools that are aligned with EP requirements. 2. PBS assessments and services have improved despite staffing shortage. 3. Cognitive screening efforts are showing improvement. **<u>Nursing Assessments</u>:** 1. Nursing Admission Assessments have been consistently completed within 24 hours. 2. The documentation regarding the presenting conditions on the Nursing Admission Assessments has improved to include specific and individualized descriptions at the time of admission. 3. The newly developed statewide Nursing Admission Assessment is

		based on the Wellness and Recovery Model. 4. Nursing has taken steps to evaluate the training needed regarding psychiatric nursing practices and topics and has developed curriculums accordingly. **Rehabilitation Therapy Assessments:** The facility engaged in activities intended to advance towards EP compliance, but significant focused work remains to be done to achieve compliance. **Nutrition Assessments:** 1. Continued to monitor Nutrition Care Assessments. 2. Converted data to Plato system, which allows for trend analysis within the department as well as by dietitian to address with general and specific training, resources, and performance evaluations. 3. Now using findings of monitoring data for performance improvement. 4. Continued to conduct case presentations within the department. **Social History Assessments:** 1. The Social Work Department is showing a change in its cultural thinking about the EP. 2. The Department has also made progress developing and implementing monitoring tools. 3. The timeliness of the seven-day and 30-day assessments is showing improvement. 4. The Department has initiated the Family Needs Assessment. **Court Assessments:** 1. MSH has a Forensic Review Panel (FRP) that reviews all court submissions and provides feedback to the WRPTs to improve compliance with requirements of the EP.

		2. Court submissions for individuals under PC 1026 and PC 1370 show some improvement in compliance during this review period.
1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. Michael Barsom, MD, Acting Medical Director 2. Nady Hanna, MD, President of Medical Staff 3. Bala Gulasekaram, MD, Chief of Psychiatry Department Reviewed: 1. The charts of 33 individuals: JK, MAH, JC, IJD, SJ, LW, JB, JS, RAP, IC, SG, CTC, JT, CAT, RO, AW, RLT, DLW, CED, NKS, JM, AMA, MC, GF, WCB, SO, JH, JA, JC-2, RF, MW, MM and SH 2. MSH Admission Psychiatric Assessment Monitoring Form, revised 3. DMH Admission Psychiatric Assessment Auditing Form 4. DMH Admission Psychiatric Assessment Auditing Form Instructions 5. DMH Integrated Psychiatric Assessment Auditing Form 6. DMH Integrated Psychiatric Assessment Auditing Form Instructions 7. DMH Physician Progress Notes (PPN) Auditing Form 8. DMH PPN Auditing Form Instructions 9. DMH Physician Transfer Note Auditing Form 10. DMH Physician Transfer Note Auditing Form Instructions 11. MSH Admission Assessment Monitoring summary data (March to July 2007) 12. MSH Psychiatric Evaluation Monitoring Form 13. MSH Psychiatric Evaluation Monitoring summary data (March to July 2007) 14. MSH Monthly Progress Notes (Psychiatry) Monitoring Form 15. MSH Monthly Progress Notes (Psychiatry) Monitoring (March to July 2007)

		16. MSH Physician Performance Data (Profile Template) 17. MSH Revised Medical Services Medical Care Policy and Procedure (Effective July 20, 2007) 18. Data regarding reviews by Health Information Management Department (HIMD) of timeliness/completeness of weekly and monthly psychiatric progress notes (March to July 2007) 19. MSH Psychology Monitoring Form 20. MSH Psychology Monitoring summary data (March to July 2007)
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostic and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Finalize statewide efforts to consolidate and standardize monitoring indicators in current forms that assess psychiatric assessments. **Findings:** MSH has revised its admission psychiatric assessment to ensure that mental status findings are elaborated on, that specifics are provided regarding history of dangerousness and that the history of present illness section is expanded. In addition, the cognitive section of the mental status exam has been expanded. This revision does not include a provisional plan of care as part of the document. DMH presented drafts of the revised DMH Admission Psychiatric Assessment Monitoring Form and Instructions and revised DMH Integrated Psychiatric Assessment Auditing Form and Instructions. This monitor's review of these instruments showed the following: 1. The DMH Admission Psychiatric Assessment Form should include a provisional plan of care. 2. The Admission Psychiatric Assessment Auditing Instructions should be revised to include the components of a complete mental status examination (D.1.c.2.ii) and requirements regarding a provisional plan

		of care. The plan must address medications (regular and PRN), specify indications for PRN medications as applicable, and include specific precautions, with reason(s) for the precautions. 3. The DMH Integrated Psychiatric Assessment Auditing Form is aligned with EP requirements. 4. The DMH Integrated Psychiatric Assessment Auditing Form Instructions should be revised to address the following (the monitor's comments are aligned with the items as they are listed on the form): a) D.1.c.iii.1 (*psychiatric history, including a review of present and past history*): The plan for management of acute medical problems is included as part of the psychiatric history. This item can complicate interpretation of the data and should be addressed elsewhere. b) D.1.c.iii.3 (*mental status examination is documented*): The mini mental status examination is included as a requirement for all individuals. However, MSH currently requires this item only for individuals with cognitive impairments. At a minimum, this item should be required for all elderly individuals and for all individuals with evidence and/or history of cognitive impairments. c) D.1.c.iii.6.d.i (*diagnostic formulation is documented*): The instructions do not specify the components of an adequate diagnostic formulation. The formulation should address relevant elements from past history, including diagnosis and treatment, and current presentation and the implications of these elements for current diagnosis and treatment. d) D.1.c.iii.7.d.i (*differential diagnosis is documented*): The instructions address resolution of the differential diagnosis (within 60 days). This item does not belong in the integrated assessment. e) D.1.c.iii.8.d.i (*current diagnosis is documented*): The instructions should include a requirement that the diagnosis is consistent

		with history and presentation. The instruction regarding justification of diagnosis in accordance with the criteria listed in DSM-IV-TR appears to duplicate another instruction in the same call. The instruction regarding presence of DSM-IV-TR checklist does not belong in the review of the integrated assessment. f) D.1.c.iii.9 (*psychopharmacology treatment plan is included*): The instructions should include specification of medications to be used, with type and dosage. g) D.1.c.iii.10 (*management of identified risks*): The instructions should require that the plan address behavioral and medical risks. In this context, the medical risks can be limited to acute problems identified upon admission. 5. The DMH Physician Progress Notes (PPN) Auditing Form is aligned with the EP. 6. The PPN Auditing Instructions should be revised to address the following: a) D.1.f.i (*progress towards objectives in the WRP*): The instruction should clearly specify the EP requirement regarding documentation of significant developments in the clinical/psychiatric status during the interval. b) The form does not include instructions regarding EP item D.1.f.iii regarding analysis of benefits and risks of chosen treatment. There needs to be clarification if this requirement is addressed in a separate tool (with instructions) in the area of medication management. c) D.1.f.iv (*assessment, monitoring and planning for high-risk behaviors are documented*): The instructions require only documentation of the risk. The instructions should specify documentation of interventions to reduce the risk, as applicable. d) The form does not include instructions regarding EP item D.1.f.vi regarding use of PRN/Stat medications. There needs to be clarification if this requirement is addressed in a separate

		tool (with instructions) in the area of medication management. e) D.1.f.vii: This item addresses the requirement regarding integration of psychiatric and behavioral modalities. The DMH form has split this requirement into two sections, adding instructions for documentation of an analysis of benefits of non-pharmacologic treatment interventions. These additional instructions are not required by the EP and may complicate interpretation of the data. 7. DMH Physician Transfer note Auditing Form and Instructions are aligned with the EP. **Recommendation 2, March 2007:** Continue to monitor this requirement and ensure samples of 20% of the total target population. **Findings:** MSH used the current Initial Admission (Psychiatric) Assessment, the Psychiatric Evaluation Monitoring and the Monthly Progress Notes (Psychiatry) Monitoring Forms to assess compliance (March to July 2007). The facility's data during the period of March to May/June 2007 are discounted because they were based on an inappropriate total target population (N) of admission assessments. This was corrected in July/July when the facility developed a method for obtaining copies of all Admission/Integrated Assessments. In addition, the facility changed the monitoring methodology so that all monitoring is done by senior psychiatrists and a stable core of selected members of the medical staff (instead of separate reporting by different programs). This method reportedly improved inter-rater reliability. Using the correct N (total number of admissions per month), the facility reviewed an average sample of 100% of the Initial Psychiatric Assessments (June and July 2007) and a sample of 49% of the Integrated Psychiatric Assessments (July 2007). The facility reviewed an average sample of 10% of monthly progress notes (March to July 2007). The

following is a summary outline of the monitoring indicators and the corresponding mean compliance rates:

Initial Admission Assessment	
DSM diagnosis consistent with history and presentation	62%
Integrated Psychiatric Assessment	
Included statements from the individual	64%
Included pertinent positive and negative findings (related to differential diagnosis)	45%
Included the diagnosis and medications given at previous facilities	5%
DSM-IV-TR addresses five axes	68%
Diagnostic formulation	50%
Included the diagnostic criteria for the given diagnosis	55%
Addressed findings which may support other diagnoses	32%
Monthly progress notes	
Current diagnosis (changes, if any, with evidence to support. Includes resolution of NOS, deferred and rule-out diagnoses, if applicable)	94%

Recommendation 3, March 2007:
Standardize the names of the monitoring instruments statewide and ensure that the facilities' progress reports use these names consistently.

Findings:
The facility has yet to implement this recommendation. This is expected to occur when the revised DMH monitoring tools (see Findings under Recommendation 1) are finalized and implemented.

Recommendation 4, March 2007:
Address and correct factors related to low compliance.

		Findings: MSH reported that some of the assessments were completed by staff who had not received sufficient training and feedback regarding requirements of the EP. The facility anticipates improved compliance with further training and feedback as well as improved sampling methods. **Other findings:** Chart reviews by this monitor still reveal deficiencies in the admission and integrated assessments (see D.1.c.i through D.1.c.iii) that must be corrected to achieve substantial compliance. **Compliance:** Partial. **Current recommendations:** 1. Finalize statewide efforts to consolidate and standardize monitoring instruments regarding psychiatric assessments and address the monitor's comments listed above. 2. Continue to monitor this requirement and ensure samples of 20% of the total target populations. 3. Provide ongoing feedback and monitoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii).
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice.

	Accreditation Counsel for Graduate Medical Education accreditation program, and	**Findings:** As of July 31, 2007, 100% of the psychiatrists (53 psychiatrists in 41 FTE positions) employed by MSH have successfully completed at least three years of psychiatry residency training in a residency program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The facility continues to utilize primary source verification to ensure compliance with this requirement. At present, 27 of the 53 psychiatrists are certified by the American Board of Psychiatry and Neurology (ABPN). **Compliance:** Substantial. **Current recommendations**: Continue current practice.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Implement the new system of Physician Quality Profile to ensure that internal monitoring data regarding psychiatric diagnosis and assessments are utilized in the processes of reprivileging and performance improvement. **Findings:** MSH has implemented the new Physician Quality Profile and compiled data for the second quarter (April to June 2007). The profile includes information related to physicians' performance in the following areas: 1. Psychiatric Evaluations (Integrated Assessments) 2. Annual Psychiatric Evaluation 3. Monthly Progress Notes

		4. Transfer Summary 5. Seclusion/Restraint Review 6. Treatment Team Leadership 7. Timeliness of Integrated Assessments, Monthly Progress Notes and Discharge Summaries 8. Attendance at Medical Staff/Committee Meetings 9. Psychopharmacology Data 10. Continuing Medical education Requirements However, the facility has yet to utilize the information derived from this system in the processes of reprivileging and performance improvement. **Other findings:** The facility must correct deficiencies outlined in all sections of D.1. regarding psychiatric diagnosis and assessments in order to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendation**: Utilize the data from the Physician Quality Profiles in the processes of reprivileging and performance improvement of the medical staff.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that there is documented rationale for deferral of items on the examination and that deferred items are subsequently addressed to

		ensure compliance with the intent of this item. **Findings:** In July 2007, MSH revised its Medical Care Policy and Procedure (Sections IB. 7, 8, & 9). The revised procedure states that no part of the physical examination may be deferred if the individual has not refused the examination. The procedure also includes requirements for referral to the program medical consultant at unit level to follow up on any part of the examination that was refused by the individual and to the WRPT to consider initiating a focus of treatment if the individual refuses parts of the physical examination three times. **Recommendation 2, March 2007:** Continue to monitor this requirement, and include refusals of the examination and follow up (as per revised Medical Services Medical Care Policy and Procedures). **Findings:** MSH used the Admission Assessment Monitoring Form to assess compliance (March to July). As mentioned earlier, the total target population was accurately identified only during June and July 2007. Reviewing 100% of the admission assessments during these two months, the facility reported mean compliance rates that are listed below for each corresponding sub-cell of the EP. **Other findings:** This monitor reviewed the charts of 12 individuals (JK, MAH, JC, IJD, SJ, LW, JB, JS, RAP, IC, SG and CTC). The review corroborates the facility's compliance data regarding review of systems, medical history, diagnostic impressions and management plan when acute medical problems are identified. In addition, this monitor found that the documentation of the neurological examination has improved compared to the last review. However, the monitor's findings still show a much

		lower compliance rate in the documentation of rationale and follow-up regarding deferral of genital/rectal examinations (JC, IJD, LW, RAP and IC). **Compliance:** Partial. **Current recommendations**: 1. Implement the revised Medical Care Policy and Procedure regarding deferrals and refusals of the physical examination or parts of the examination. 2. Continue to monitor this requirement, and include deferrals and refusals of the examination and follow up (as per revised Medical Services Medical Care Policy and Procedures).
D.1.c.i.1	a review of systems;	100%
D.1.c.i.2	medical history;	100%
D.1.c.i.3	physical examination;	100%
D.1.c.i.4	diagnostic impressions; and	84%
D.1.c.i.5	management of acute medical conditions	100%
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that the mental examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination."

		Findings: Recently, the facility improved the format of the admission psychiatric assessment, including a section to ensure elaboration on findings of the mental status examination. The facility has yet to implement this format. Using the Initial Admission Assessment Monitoring Form, the facility conducted monitoring in June and July 2007 based on an accurate target population (N), a revised methodology and a sample of 100%. The mean compliance rates are listed for each corresponding sub-cell below. The facility has improved the delineation of data regarding D.1.c.ii.2 (complete mental status examination) and D.1.c.ii.4 (admission diagnosis). In general, the facility's data showed some decreases in compliance rates during these two months compared to the results obtained in prior months (March to May 2007). This decline appears to be related to the improved methodology of monitoring. As mentioned earlier, effective June 2007, all monitoring was conducted by senior psychiatrists and select members of the medical staff. **Recommendation 2, March 2007:** Ensure documentation of a provisional plan of care upon the completion of the initial psychiatric examination. **Findings:** MSH has yet to implement this recommendation. **Recommendation 3, March 2007:** Ensure that monitoring of the admission psychiatric examination addresses completeness of the examination and that the overall compliance rate accounts for the completeness of each item.

		Findings: The DMH has addressed this recommendation (see Findings under Recommendation 1 in D.1.a). **Recommendation 4, March 2007:** Ensure monitoring of a 20% sample of the target population. **Findings:** MSH has implemented this recommendation. Since June 2007, senior psychiatrists have been auditing 100% of new admissions for the reporting month to ensure an adequate sample size. **Other findings:** Chart reviews by this monitor demonstrate that, with few exceptions (e.g. IC), MSH has maintained improvements in the documentation of dangerousness upon admission (i.e. history of aggression, suicidality and self-abuse). However, there continue to be significant deficiencies regarding the following: 1. Lack of an initial plan of care as part of the assessment 2. Incomplete mental status examination, particularly the lack of narrative needed to elaborate on positive mental status findings. Examples include auditory hallucinations (MAH, IJD, JB, IC and SG), persecutory delusions (JK, JB, RAP and CTC) and nihilistic delusions (RAP). In addition, the assessment of insight and judgment continues to be generic. These deficiencies must be corrected to achieve substantial compliance. **Compliance:** Partial.

		Current recommendations: 1. Ensure that mental status examinations are completed on all admission psychiatric assessments. An adequate narrative must be entered whenever indicated to complete the section titled "elaborate on positive mental status examination." 2. Ensure documentation of a provisional plan of care upon the completion of the initial psychiatric examination. 3. Monitor this requirement based on a review of a 100% sample.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	*Pertinent history leading to admission*: 92%. *Pertinent past history*: 76%
D.1.c.ii.2	complete mental status examination;	*Mental Status Examination (MSE) completed*: 91% *Positive findings of the MSE addressed*: 51%
D.1.c.ii.3	admission diagnoses;	*Admission Diagnosis: Axes I – V addressed*: 83% *DSM diagnosis consistent with history and presentation*: 62%.
D.1.c.ii.4	completed AIMS;	100%
D.1.c.ii.5	laboratory tests ordered; and	99%
D.1.c.ii.6	consultations ordered.	93%
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure completeness of the integrated assessment within the specified time frame. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the

		first seven days of admission. **Recommendation 2, March 2007:** Ensure that monitoring of the integrated psychiatric examination addresses completeness of the examination and that overall compliance rate accounts for the completeness of each item. **Recommendation 3, March 2007:** Ensure monitoring of a 20% sample of the target population. **Findings:** MSH reviewed 49% of the integrated psychiatric assessments during July 2007. Using the Psychiatric Evaluation Monitoring Form, the facility assessed its compliance. In this process, MSH completed two inter-rater reliability studies. Senior psychiatrists met to review the same charts item by item and resolved discrepancies in interpretation. MSH plans to continue to assess inter-rater reliability by completing additional studies to reach an adequate threshold by December 2007. The mean compliance rates are listed for each corresponding sub-cell below. The facility improved the delineation of data regarding D.1.c.iii.3 (mental status examination) and D.1.c.iii.9 (psychopharmacology treatment plan). In general, the facility's data showed some decreases in compliance rates during July 2007 compared to the results obtained in prior months (March to June 2007). This decline appears to be related to the improved methodology of monitoring. **Other findings:** In reviewing 12 charts (JK, MAH, JC, IJD, SJ, LW, JB, JS, RAP, IC, SG and CTC), this monitor found lower compliance due to a pattern of deficiencies similar to that described in the previous report. The following are examples:

		1. The integrated assessment was completed approximately four months after admission (SJ). 2. Important components are missing, including: a) Medical history (CTC); b) Contraindications to seclusion/restraints (MAH) 3. Important components are inadequately assessed, including: a) Strengths were based on generic characteristics (RAP, JK and SG); b) Diagnostic formulations were listed as a summary of the case formulations (LW and IC); c) Many of the diagnostic formulations were based on a rehash of the history rather than a review of the implications for diagnosis and treatment; and 4. Incomplete mental status examinations, including: a) Nature of auditory hallucinations (JB); b) Specifics regarding the cognitive examination (JK, MAH, JC, LW, JB,); and c) Specifics regarding impaired judgment and insight (MAH, IJD, JB, IC and CTC). These deficiencies must be corrected to achieve substantial compliance. **Compliance:** Partial. **Current recommendations:** 1. Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the integrated assessments correct the deficiencies outlined by this monitor. 2. Monitor this requirement based on a review of a 100% sample.

D.1.c.iii.1	psychiatric history, including a review of present and past history;	*Included pertinent positive and negative findings (related to differential diagnosis)*: 45% *Included the diagnosis and medications given at previous facilities: 5%* *Included the effectiveness of the medication given at the previous facility*: 23% *Previous psychiatric history*: 50%
D.1.c.iii.2	psychosocial history;	77%
D.1.c.iii.3	mental status examination;	*Attitude/Cooperation:* 91% *General Appearance:* 64% *Motor Activity:* 73% *Speech:* 55% *Mood/Affect:* 55% *Thought process/content*: 41% *Perceptual Alterations:* 64% *Alertness:* 64% *Orientation:* 68% *Memory (recent, remote, and recall):* 41% *Attention:* 36% *Fund of general knowledge:* 59% *Abstraction ability:* 73% *Judgment:* 14% *Insight:* 32% *Folstein, MMSE (if cognitively impaired):* 70% (sample was 20%)
D.1.c.iii.4	strengths;	64%
D.1.c.iii.5	psychiatric risk factors;	*Risk Assessment: addresses relevant demographic risk factors:* 9% *Addresses history of suicide attempts:* 68% *Addresses current clinical symptoms, including suicidal*

		ideation/threats/plans to harm self: 77% *Addresses psychosocial losses:* 18% *Risk factors for seclusion/restraint addressed: 36%* *Risk of aggression/fire setting/elopement/etc. addressed:* 50%
D.1.c.iii.6	diagnostic formulation;	*DSM-IV (TR) addresses 5 axes:* 68% *Diagnostic formulation:* 50%
D.1.c.iii.7	differential diagnosis;	*Included the diagnostic criteria for the given diagnoses:* 55% *Addressed findings which may support other diagnoses:* 32%
D.1.c.iii.8	current psychiatric diagnoses;	*DSM-IV (TR) addresses 5 axes:* 68%
D.1.c.iii.9	psychopharmacology treatment plan; and	*Reasons for continuing the medications individual came with:* 23% *Rationale for PRN*: 23% *Statement that patient agrees to take medication after explaining the benefits and risks:* 50%
D.1.c.iii.10	management of identified risks.	59%
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders. **Findings:** During this review period, MSH has provided several training programs.

The following is an outline of the relevant programs, with dates, names and affiliation of instructors and number of psychiatrists receiving the training:

PROGRAM	DATE	INSTRUCTOR	# TRAINED
Overview of Anticonvulsants and Effects on Cognition	6/20/07	Joseph Sirven, MD, Louisiana State University	26
Cognitive Deficits and Schizophrenia	7/18/07	Michael Green, PhD, University of California at Los Angeles	41
Review of the Neurocognitive Effects of Antipsychotics in the CATIE Trial	8/15/07	Christopher Heh, MD, Director of Professional Education at MSH, University of California at Irvine.	29
Proper Use of AIMS	8/22/07	Edmund Pi, MD, University of South California	41

Recommendation 2, March 2007:
Ensure that diagnostic formulations and differential diagnoses address the clinically appropriate needs of all individuals and that the diagnostic process includes adequate interventions and follow up to finalize diagnoses.

Recommendation 3, March 2007:
Same as in C.1.a.

Findings:
Same as in C.1.a.

		Other findings: Chart reviews by this monitor show that MSH has maintained progress in the overall decrease in the number of individuals receiving diagnostic categories that are listed as not otherwise specified (NOS). However, in the charts of individuals currently receiving these diagnoses, there continues to be a pattern of inadequate documentation, evaluation and updates in the WRPs of these disorders. Examples include: 1. Psychotic Disorder, NOS (RO, RLT, CED and NKS); 2. Dementia, NOS (JM); 3. Impulse Control Disorder, NOS (CAT) 4. Mood Disorder, NOS (MC); 5. Cognitive Disorder, NOS (AW, AMA and GF); 6. Mood Disorder, NOS (MC); 7. Depressive Disorder, NOS (JT). **Compliance:** Partial. **Current recommendations:** 1. Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders. 2. Same as in C.1.a.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as D.1.a. **Findings:** Same as D.1.a.

		Compliance: Partial. **Current recommendations**: Same as D.1.a.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as D.1.d.i. **Findings:** Same as in D.1.d.i. **Other findings:** Same as in D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as D.1.d.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** The facility has continued its current practice. At present, no individual has "no diagnosis" listed on Axis I.

		Other findings: Chart reviews by this monitor did not show any Axis I diagnosis listed as "no diagnosis." **Compliance**: Substantial. **Current recommendations**: Continue current practice.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Assess and correct factors related to non-compliance with the requirement for weekly progress notes on the admission teams. **Findings:** MSH used the Psychiatric Evaluation Monitoring Form to assess its compliance with this recommendation (March to June 2007). Reviewing an average sample of 37% of an estimated number of individuals with less than 60 days length of stay, the facility reported a mean compliance rate of 56%. The facility reports that instruction had been provided to the medical staff regarding compliance with this requirement. **Other findings:** MSH presented data based on reviews by the Health Information Management Department (HIMD) to assess the timeliness of weekly and monthly progress notes. The data do not segregate the timeliness of weekly notes from monthly notes. Reviewing an average sample of 31% (March-July 2007), MSH reported a mean compliance rate of 54%. MSH plans to use this mechanism to delineate the frequency of weekly and monthly notes.

		This monitor reviewed charts of six individuals on the admissions units (JB, JS, RAP, IC, SG and CTC) to assess the frequency of psychiatric notes during the first 60 days of admission. The review showed compliance in three charts (IC, SG and CTC) and non-compliance in three. **Compliance:** Partial. **Current recommendations**: 1. Monitor the frequency of weekly and monthly documentation as required by the EP, based on at least a 20% sample. 2. Assess and correct factors related to low compliance.
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Address and correct factors related to low compliance with this requirement. **Findings:** MSH reported that the senior psychiatrists provided feedback to staff psychiatrists regarding the areas that require improvement, including discussions at medical staff meetings of the facility's data. Reportedly, samples of good documentation were provided to all staff psychiatrists in June and August 2007. The facility reported that the medical staff was specifically informed that generic statements from the PDR or other sources regarding the risks and benefits of treatment were inadequate and that the discussion of risks and benefits must be tailored to the individual's current status.

		Recommendation 2, March 2007: Continue monitoring to address all above mentioned deficiencies. **Findings:** MSH used the Monthly Progress Note (Psychiatry) Monitoring Form to assess compliance (March to July 2007). The average sample was 10% (items D.1.fi through D.1.f.iv and D.1.f.vi). The mean compliance data and monitoring indicators, as needed, are presented for each sub-cell below. Regarding item D.1.f.v, the facility used the Psychopharmacology Monitoring Forms for Polypharmacy, Benzodiazepines and Anticholinergic Medications to assess compliance. In addition, the facility used the DUE monitoring indicators that accompanied the DMH Psychotropic Medication Guidelines to assess compliance regarding the use of new-generation antipsychotic medications. These data are addressed in Section F.1. To assess compliance with item D.1.f.vii, the facility used the Psychology Monitoring Form and reviewed 100% sample of all PBS plans. **Recommendation 3, March 2007:** Ensure that monitoring instructions are aligned with the elements listed in recommendation 2 September 2006. **Findings:** See Findings under Recommendation 1 in D.1.a. **Recommendation 4, March 2007:** Monitor documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention. **Findings:** MSH has yet to implement this recommendation.

		Recommendation 5, March 2007: Address and correct discrepancies between findings using the Monthly Progress Notes Monitoring Form and the Psychopharmacology Review Monitoring Form. **Findings:** The facility implemented the DUE forms that accompanied the new individualized medication guidelines (see F.1) to monitor item D.1.f.v regarding management of high-risk medication uses. This should decrease the potential for discrepant findings when two different methods are used. **Other findings:** Chart reviews by this monitor indicate that the facility has made some progress in the documentation of psychiatric reassessments in the monthly notes. Some charts contain an improved overall format of documentation (e.g. RF, MW, MM and SH), but the documentation of interval history is mostly limited to a listing of the current objectives with a statement regarding whether the objective was met, partially met or not met. This documentation does not provide any meaningful information regarding important developments during the interval. In addition, the documentation of benefits and risks of current treatment is mostly focused on a generic review of potential side effects and benefits without relevance to the current status of the individual. This monitor also reviewed the charts of five individuals who have experienced the use of seclusion and/or restraints. The purpose of this review was to assess the psychiatric reassessments of the appropriateness of the use of PRN medications prior to seclusion and/or restraints. This review is also relevant to the requirement in D.1.f.vi. The review showed that PRNs were not used when indicated and, when used, there was no review of this use to ensure that regular treatment was adjusted in a timely and appropriate manner. Both of

		these situations can have negative impact regarding the need for seclusion/restraints. The following are examples: 1. PRN medications were not ordered as appeared to be indicated by the progressive symptoms. This could have averted the use of seclusion/restraints (AHW and CMW). 2. The selection of the PRN medication was not based on the individual's history and presentation, and appeared to be contraindicated per review of the WRP documentation (CML). 3. The psychiatric reassessments do not adequately document the appropriateness and/or efficacy of the PRN regimen (NM). 4. Multiple PRN regimens were prescribed, apparently, by on-call physicians, without documentation by the attending physician of the circumstances requiring the use of these medications and/or the appropriateness of these regimens (MC). 5. There is no documentation of a face-to-face assessment by the psychiatrists within one hour of the use of a Stat medication. In general, the charts reviewed by this monitor suggested lower compliance rates than those reported by the facility. **Compliance:** Partial. **Current recommendations**: 1. Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the psychiatric reassessments correct the deficiencies outlined by this monitor. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Monitor documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this

		intervention.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	*Progress towards objective in the WRP*: 87% *Pharmacologic (Rationale for continuation of medications or proposed plans:* 89%. *Non-pharmacologic*: 85%.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	*Current diagnosis (changes, if any, with evidence to support. Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable*: 94%.
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	*Benefits and risks of current pharmacologic treatment; includes benzodiazepines, anticholinergics, and polypharmacy, if applicable:* 79%.
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	*Risk behaviors – suicide, S.I.B., aggression, elopement, falls, etc.:* 87%.
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	Same as in F.1.
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	*Rationale for PRN medications and review of rationale for ongoing PRN/STAT medications used:* 72%.
D.1.f.vii	Verification in a clinically justifiable manner,	*Positive behavior support teams and team psychologists integrate their*

	that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	*therapies with other treatment modalities, including drug therapy:* 35%.
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to monitor using current instrument. **Findings:** MSH used the Physician Transfer Summary Monitoring Form (March to July 2007) to assess compliance. Reviewing an average sample of 41% of inter-unit transfers in the reporting month, the facility's data are summarized below (mean compliance rates listed for each corresponding indicator): 1. Reason for transfer: 67%; 2. Five Axis Diagnosis: 55%; 3. Psychiatric course of hospitalization: 68%; 4. Medical history and current medical conditions: 58%; 5. Current target symptoms: 65%; 6. Psychiatric risk factors: 51%; 7. Review of medications: 53%; 8. Current barriers to discharge: 54%; and 9. Anticipated benefits of transfer: 41%.

		Recommendation 2, March 2007: Address and correct factors related to low compliance. **Findings:** MSH recognized that the documentation of anticipated benefits of transfers had the lowest compliance rate. The facility reported that Medical Staff was instructed to address specific benefits of transfers such as providing care and treatment in an environment that is conducive to meeting the individual's specific therapeutic and forensic needs. **Recommendation 3, March 2007:** Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers. **Findings:** MSH has yet to implement this recommendation. **Other findings:** This monitor reviewed the charts of six individuals (JB, WCB, JC, SO, JH and JA). All charts contained identifying information, some discussion of course of psychiatric hospitalization and a review of current diagnosis. However, the review of current symptoms, psychiatric risk factors, response to pharmacotherapy, barriers to discharge and anticipated benefits of transfer was either absent or expressed in generic terms. Some assessments (e.g. WCB) provided no meaningful information other than the identifying information and current diagnosis. **Compliance:** Partial.

		Current recommendations: 1. Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.

2. Psychological Assessments		
		Methodology: Interviewed: 1. Swati Roy, PhD, Chief of Psychology 2. Edwin Poon, PhD, Psychologist 3. Kirk Hartley, PhD, Psychologist 4. Ashwind Singh, Psychology Intern 5. Susan Shifflett, Psychology Intern 6. Ana Peeks, PsyD, Psychologist 7. Leora Scheffres, PhD, Psychologist 8. Cindy Huang, PhD, Psychologist 9. Steve Young, PsyD, Psychologist 10. Brian Hough, PhD, Senior Psychologist 11. Wilma Fuentes, RN, PBS Team Member 12. Bo Kasperowicz, PT, PBS Team Member 13. Crystal Amey, PT, PBS Team Member 14. LaTasha Fields, PT, PBS Team Member 15. Katherine Nguyen, RN, PBS Team Member 16. Eric McMullen, PT, PBS Team Member 17. AL Munoz, PT, PBS Team Member 18. Gretchen Hunt, BY CHOICE Coordinator 19. Doug Strosnider, Mall Director, Director of Central Program Services 20. Ken Layman, Treatment Enhancement Coordinator Reviewed: 1. Charts of 75 individuals: ABS, AC, AEE, AF, BR, CAP, CC, CD, CG, CJ, CMW, CX, DC, DM, DMG, DRA, DS, DY, EM, FG, FL, GD, HMT, IC, JA, JB, JC, JD, JG, JH, JR, KA, KR, LAJ, LO, LP, MAA, MB, MDB, ME, MJ, MJA, ML, MLB, MP, MV, MW, NR, NV, OG, OM, PD, PW, QHV, RAL, RC, RF, RL, RM, RR, RT, RU, RW, SC, SCD, SFY, SG, SH, SLP, TM, TP, VG, VPN, VR, and WB

		2. Positive Behavior Support Plans. 3. List of Individuals by Program/Unit, Needing Behavioral Interventions 4. List of High Utilizers of Seclusion and Restraints 5. Staff training Documentation on PBS plans 6. Psychologist Performance Review 7. Statewide Positive Behavior Support Plan Monitoring Form 8. Structural and Functional Assessments 9. Questions About Behavioral Function in Mental Illness (QABF-MI) data 10. Procedures Steps for Behavioral Consultation Committee Form 11. Psychologists Weekly Monitoring and Mentoring Log. 12. List of Individuals 22 Years Old and Younger 13. List of Individuals on PBS Plans 14. BY CHOICE Staff Competency Audit Report 15. BY CHOICE Monitoring Form and Instructions: Competency and Fidelity Check 16. Program by Unit by Assessment Completed/Needed 17. PBS Plan Tracking Spreadsheet 18. DMH Psychology Manual 19. Inventory of Assessments 20. Psychology Assessment Protocols 21. Integrated Assessment Psychology Section 22. Individual PBS Plan Training Record 23. List of Individuals with Diagnostic Inconsistencies 24. Neuropsychology Service Referral Tracking Database 25. List of Individuals by Program by Unit Needing Behavioral Intervention 26. List of Individuals who have not made timely progress on PBS Plan 27. Functional Behavioral Assessment 28. Structural Assessments 29. List of School–Age/Other Individuals needing cognitive and academic assessments within 30 days of admission

		30. List of Number of Completed Consultation for Educational or Other Psychological Testing 31. Neuropsychological Assessments 32. MSH Psychology Manual
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1-3, March 2007:** 1. Finalize and implement approved version of the DMH Psychology Manual. 2. Fully implement the protocols and procedures in the DMH Psychology Manual. 3. Continue the practice of orienting new staff to the manual. **Findings:** MSH has implemented the approved version of the DMH Psychology Manual. According to Swati Roy, Chief of Psychology, the Manual has been distributed to the psychology staff and the manual was discussed with the staff at the August 2007 staff meeting. All psychology protocols are included in the Manual. According to Swati Roy, psychology staff was trained on the newly approved Manual and all the protocols during the June and August 2007, psychology staff meeting (DMH Integrated Psychological Assessment, DMH Focused Assessment, Diagnostic Clarification, DMH Suicide Risk Assessment, Behavior Guidelines, Cognitive/Academic Assessment, Personality Assessment, Cognitive Screening, and Malingering Protocol). This monitor reviewed the Psychology Manual, assessment protocols, training data, and interviewed Swati Roy, Chief of Psychology and her senior staff. This monitor's findings are in agreement with MSH's report.

<table>
<tr><td></td><td></td><td>Compliance:
Substantial.

Current recommendation:
Continue the practice of orienting new staff to the manual.</td></tr>
<tr><td>D.2.b</td><td>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Complete academic and cognitive assessments of new admissions on a timely basis.

Findings:
MSH has tracked and monitored all individuals 22 years of age and younger to ensure that the assessments are conducted on time. MSH used item #1 from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 89% compliance. The table below with its monitoring indicator showing the number of individuals 22 years of age or younger admitted per month (N), the number of individuals who met criteria for the academic and cognitive assessments (n), and the percentage of compliance obtained (%C), is a summary of the facility's data.

Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-aged and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>3</td><td>4</td><td>2</td><td>7</td><td>5</td><td></td></tr>
<tr><td>n</td><td>3</td><td>4</td><td>2</td><td>7</td><td>5</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
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		<table><tr><td>%C- 1</td><td>67</td><td>100</td><td>100</td><td>100</td><td>80</td><td>89</td></tr></table> As the data in the table above shows, MSH has tracked and assessed all individuals 22 years of age and under, and required timely cognitive and academic assessments be conducted on them. According to MSH's report and information from Swati Roy, Chief of Psychology, the reasons for testing not being conducted on the two individuals who were not tested were repeated refusal by one individual and psychiatric instability in the other. This monitor reviewed eight charts of individuals under 22 years of age and who required cognitive and academic assessments (CAP, CJ, ABS, MAA, IC, AC, MB, and DRA). Four of them (CAP, IC, MB, and AC) had their assessments in a timely manner, one of them (ABS) was not conducted in a timely manner, and three of them (CJ, MAA, and DRA) did not have their assessments completed due to the individuals' refusal and/or psychiatric instability. **Compliance:** Partial. **Current recommendation**: Complete academic and cognitive assessments of new admissions on a timely basis.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** MSH has developed a psychology staff Performance Profile Form and revised the re-privileging system. The psychology staff was oriented

		to the Performance Profile Form and re-privileging system at their August 2007 staff meeting. This monitor reviewed credentials and practice privileges of psychologists in the psychology department, and the psychologists' performance audit forms. All psychologists at MSH who are responsible for performing or reviewing psychological assessments and evaluations meet the hospital's credentialing and privileging requirements. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Partial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that all psychological assessments have a statement of the reasons for referral and ensure that the statement is concise and clear. **Findings:** MSH audited Focused Assessments, using item #3 (*All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical questions(s) for the assessment*) to address this recommendation, reporting 73%

		compliance. This monitor reviewed 14 charts (AF, CG, JA, KR, MJA, ML, MLB, MP, OG, PW, RM, SH, TM and VG). Twelve of them had a clear and concise statement on the referral reasons(s) (AF, CG, KR, MJA, ML, MLB, MP, OG, PW, SH, TM and VG), and two of them did not have a clear statement and/or included additional information not belonging to this section (JA and RM). **Recommendation 2, March 2007:** Ensure that there is continuity amongst the various sections that address referral questions to appropriate conclusions, recommendations and therapies available at MSH. **Findings:** MSH audited Focused Assessments, using items #3, #4, and #8 from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting a combined mean compliance rate of 65%. The monitoring indicators and their individual means are as follows: #3: *All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical questions(s) for the assessment*—73% compliance. #4: *All psychological assessments,, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*—67% compliance. #8: *All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions*—70% compliance.

		This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Five of them (MR, RWW, JD, JA, and RF) had clear and concise clinical/referral statements, included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested intervention priorities useful to the individual's WRP team. The remaining four (BR, RM, SG, and VG) were lacking in one or more areas. **Current recommendations:** 1. Ensure that all psychological assessments have a statement of the reasons for referral and ensure that the statement is concise and clear. 2. Ensure that there is continuity amongst the various sections that address referral questions to appropriate conclusions, recommendations and therapies available at MSH.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations. **Findings:** MSH audited Focused Assessments, using item #4 (*All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 67% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Five of them (MR, RWW, JD, JA, and RF)

		addressed the clinical/referral questions, included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested intervention priorities useful to the individual's WRP team. The remaining four (BR, RM, SG, and VG) were lacking in one or more areas. **Current recommendations**: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at Mall groups;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy. **Findings:** MSH audited Focused Assessments using item #5 (*All psychological assessments, consistent with generally accepted professional standards of care, shall specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at Mall groups*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 51% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Three of them (MR, VG, and RF) included information sufficient to meet the criteria of this cell as detailed in the DMH Psychological Assessment Monitoring Form Instructions. The remaining six of them (RWW, BR, JD, JA, RM, and SG), did not include all the requirements. Psychological examiners should be trained to familiarity with the monitoring instructions necessary to meet the requirement of this cell.

		Current recommendation: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.
D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that assessments are based on current, accurate, and complete data. **Findings:** MSH audited Focused Assessments, using item #6 (*All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 70% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Two of them (JA, RF) included the necessary identification information, sources of information, and behavioral observation of the individual; the remaining seven of them (RM, VG, SG, RWW, BR, RM, and JD) failed to include one or more of the required information, such as insufficient identification information (JD, BR, and RWW) or insufficient sources of information (RM). **Current recommendation**: Ensure that assessments are based on current, accurate, and complete data.
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a	**Current findings on previous recommendation:**

	full positive behavior support plan is required;	**Recommendation, March 2007:** Ensure that all psychological assessments of individuals with maladaptive behaviors determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required. **Findings:** MSH audited Focused Assessments, using item #7 (*All psychological assessments, consistent with generally accepted professional standards of care, shall determine whether behavioral supports or interventions (e.g. behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 24% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Four of them (RM, RF, SG, and JA) addressed the issue of behavior supports or interventions. The remaining five (RWW, BR, JD, VG, and MR) failed to address this issue or give a rationale for their conclusion. **Current recommendation**: Ensure that all psychological assessments of individuals with maladaptive behaviors determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required.
D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.

		Findings: MSH audited Focused Assessments, using item #8 (*All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 70% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Five of them (JA, MR, RF, JD, and SG) included implications of the findings for interventions and recommended interventions aligned with the findings. Four of them (RWW, BR, RM, and VG) did not address each of the findings with an appropriate recommendation for intervention(s), **Current recommendation**: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all focused psychological assessments meet this requirement. **Findings:** MSH audited Focused Assessments, using item #9 (*All psychological assessments, consistent with generally accepted professional standards of care, shall identify any unresolved issues encompassed by the assessments and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues*) from the DMH Psychological

		Assessment Monitoring Form to address this recommendation, reporting 37% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). Unresolved issues were noted in two of them (RM and BR). One (BR) identified the unresolved issue and specified the timeline for resolving the issue, and the other (RM) failed to specify a timeline for resolving the issue. **Current recommendation**: Ensure that all focused psychological assessments meet this requirement.
D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 2. Abide by the American Psychological Association Ethical Standards and Guidelines for testing. **Findings:** MSH audited Focused Assessments, using item #10 (*All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 48% compliance. This monitor reviewed nine Focused Assessments (RWW, BR, JD, JA, RM, RF, VG, SG, and MR). All nine of them had a statement of

		confidentiality and the instruments used for the assessments were appropriate for the referral questions. However, this monitor is unable to speak to the techniques, the procedures and process of administration of the test/assessment battery. **Current recommendations:** 1. Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 2. Abide by the American Psychological Association Ethical Standards and Guidelines for testing.
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all psychological assessments of all individuals residing at MSH admitted before the effective date hereof be reviewed, by qualified clinicians in psychological testing, and revised as needed to meet EP requirements. **Findings:** MSH reviewed 706 charts of individuals who were admitted to the facility prior to June 1, 2006, using item #11 (*All psychological assessments of all individuals who were admitted before June 1, 2006, shall be reviewed by qualified clinicians with demonstrated competency in psychological testing and as indicated, revised to meet the criteria*) from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 90% compliance. MSH also identified an additional 391 charts of individuals admitted prior to June 1, 2006, and never had their Integrated Psychological Assessments completed. Forty-five percent of those individuals were assessed.

		This monitor reviewed 13 charts (DS, BW, CC, TP, RT, JC, RL, CD, VR, ABS, MDB, JH, and JF) of individuals admitted to MSH prior to June 1, 2006. Eight of them (DS, BW, CC, TP, RT, JC, VR, and ABS) were reviewed and/or revised as appropriate, and five of them (RL, CD, MDB, JH, and JF) of them were yet to be reviewed. **Compliance:** Partial. **Current recommendation**: Ensure that all psychological assessments of all individuals residing at MSH admitted before the effective date hereof be reviewed, by qualified clinicians in psychological testing, and revised as needed to meet EP requirements.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	**Compliance:** Partial.
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that integrated psychological assessments are conducted in a timely manner as required.

Findings:
MSH audited the Integrated Assessment, Psychology Section for timeliness, reporting average compliance rates of 36% on assessments completed within five days, and 42% on assessments completed within seven days. The table below showing the number of admissions per month (N), the number of Psychology Integrated Assessments audited (n), and the percentage compliance obtained (%C) is a summary of the facility's data.

	March	April	May	June	July	Mean
N	38	41	36	32	45	
n	38	41	36	32	45	
%S	100	100	100	100	100	
%C - =<5 days	32	17	42	38	51	36
%C -=<7 days	34	24	47	44	60	42

According to the Chief of Psychology, the low compliance was due to shortage of staffing.

This monitor reviewed 27 charts (JB, EM, SH, WB, JR, RU, JH, CX, MW, PD, RC, MV, LO, RAL, DM, MB, SLP, AF, MJ, RT, SCD, DMG, DC, JJS, ME, RT and AEE). Ten of them (MB, JB, EM, SH, WB, JR, RU, JH, CX, and MW) did not have completed IAP's. Five of the remaining 17 were timely (AEE, RT, DM, RAL, and LO), and 12 of them (MV, RC, PD, ME, JJS, DC, DMG, SCD, RT, MJ, AF, and SLP) were not completed in a timely manner,

Current recommendation:
Ensure that integrated psychological assessments are conducted in a timely manner as required.

<table>
<tr>
<td>D.2.f.i.1</td>
<td>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2007:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.

Findings:
MSH used item #13 from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 77% compliance. The table below with its monitoring indicator showing the number of admissions per month (N), the number of IAPs reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Address the nature of the individual's impairments to inform the psychiatric diagnosis

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n</td><td>17</td><td>12</td><td>15</td><td>13</td><td>24</td><td></td></tr>
<tr><td>%S</td><td>45</td><td>29</td><td>42</td><td>41</td><td>53</td><td></td></tr>
<tr><td>%C- #13</td><td>47</td><td>83</td><td>73</td><td>85</td><td>96</td><td>77</td></tr>
</table>

This monitor reviewed 11 charts (SLP, VPN, AF, JH, AEE, RT, SCD, DMG, DC, JJS, and ME). Nine of them met criteria for this recommendation (ME, JJS, DC, DMG, SCD, RT, AEE, VPN, and SLP), and two of them (AF and JH) did not.

Current recommendation:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.
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<tr>
<td>D.2.f.i.2</td>
<td>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2007:
Ensure accurate evaluation of psychological functioning that informs that WRPT of the individual's rehabilitation service needs.

Findings:
MSH used item #14 from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 67% compliance. The table below with its monitoring indicator showing the number of admissions per month (N), the number of IAP's reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n</td><td>17</td><td>12</td><td>15</td><td>13</td><td>24</td><td></td></tr>
<tr><td>%S</td><td>45</td><td>29</td><td>42</td><td>41</td><td>53</td><td></td></tr>
<tr><td>%C- #14</td><td>41</td><td>50</td><td>53</td><td>92</td><td>100</td><td>67</td></tr>
</table>

This monitor reviewed ten charts (MV, RC, PD, LO, RAL, DM, TP, CC, RW, and DS). Five of them (RW, CC, DM, PD, and RC) provided sufficient information to inform the WRPT of the individual's rehabilitation service needs, and five of them (DS, TP, RAL, LO, and MV) did not.

Current recommendation:
Ensure accurate evaluation of psychological functioning that informs that WRPT of the individual's rehabilitation service needs.
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<tr>
<td>D.2.f.ii</td>
<td>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and

Recommendation, March 2007:
Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.

Findings:
MSH addressed this recommendation by identifying individuals in need of behavioral support through analysis of case tracking, trigger list, and IAP's. The table below showing the data source, the number of individuals needing behavioral support, and the number of cases that resulted in implementation of behavior guidelines or PBS plans is a summary of the facility's data.

Data Sources	# of Individuals needing Behavior Guidelines and/or PBS Plan	# of completed Behavior Guidelines and/or PBS Plans by qualified psychologists
Submitted IAPS (n=363)	9	3
Submitted Case Tracking Spread-sheets (n=315)	12	7
Trigger List (March-July 2007) of high utilizers of S&R	36	12

The data in the table above shows that all individuals in need of behavioral support services are not receiving the services in a timely manner. Only 38% of the individuals are on intervention plans.

Item #15 (*If behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports*) of the DMH

		Psychology Monitoring Form addresses this recommendation. MSH should use this item to monitor this recommendation. This monitor reviewed 11 (KA, DY, RM, KR, TP, KS, NR, MP, MC, ML, and JG) PBS plans. In all cases, functional assessments were completed. One structural assessment was not completed (KR), and in four of them (PW, MC, TP, and KR) the structural assessments were not comprehensive. **Current recommendation**: Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses. **Findings:** MSH used items #16-#21 from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 53%, 20%, 17%, 38%, and 0% compliance respectively. The table below with its monitoring indicators showing the number of admissions by month (N), the number of IAPs completed in each month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data. #16: *Additional psychological assessments are performed as appropriate, where psychological information is otherwise insufficient.*

#17: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "differential diagnosis."*

#18: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out."*

#19: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred."*

#20: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis."*

#21: *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS" diagnoses.*

	Mar	Apr	May	Jun	Jul	Mean
N	38	41	36	32	45	
n	15	11	14	11	3	
%S	39	27	39	34	7	
%C - #16	27	64	36	73	67	53
n	1	0	5	0	0	
%S	3	0	14	0	0	
%C-#17	0	-	40	-	-	20
n	2	2	3	0	0	
%S	5	5	9	0	0	
%C-18	0	50	0	-	-	17
n	7	3	4	0	0	
%S	18	7	11	0	0	
%C-19	14	100	0	-	-	38
n	6	8	4	5	1	

%S	16	20	11	16	2	
%C-#20	67	75	25	20	0	
n	3	0	3	0	0	
%S	8	0	8	0	0	
%C- #21	0	-	0	-	-	0

This monitor reviewed the list of individuals with Rule-out and Deferred diagnoses. The list contained 25 individuals whose initial diagnoses of rule-out and/or deferred is over 60 days, and follow-up assessments have not been completed.

This monitor reviewed nine charts (SLP, MJ, RT, SCD, DMG, DC, JJS, ME, and AEE) of individuals with diagnostic uncertainties. Six of them (SLP, RT, SCD, DMG, JJS, and ME) had follow- up assessments conducted to resolve their diagnostic uncertainties, and three of them (DC, AEE, and MJ) did not have their follow-up assessments completed.

Recommendation 2, March 2007:
Ensure that the facility's monitoring instrument that addresses "no diagnosis" are aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.

Findings:
According to the Chief of Psychology, the DMH Psychological Assessment Monitoring Form and Instructions have been revised to align with the requirements of the EP and approved by their Chief CRIPA Consultant and DMH.

This monitor reviewed the DMH Psychology Assessment Monitoring Form (MD-C 9017, 05/07), and the DMH Psychology Assessment Monitoring Form Instructions (MH-C 9017, 07/07). The source for this recommendation comes from item #20 of the Assessment

		Monitoring Form, and items #16- #21 of the Instructions Form. **Current recommendation**: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.
D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters. **Findings:** MSH Psychologists have received training on the use of the DMH Clinical Indicator List, which includes assessment instruments appropriate for individuals whose primary/preferred language is Spanish. MSH used items #22- #23 from the DMH Psychological Assessment Monitoring Form to address this recommendation, reporting 67% compliance for both items. The table below with its monitoring indicators showing the number of admissions per month (N), the number of individuals whose preferred/primary language is not English (n), and the percentage of compliance obtained (%C) is a summary of the facility's data. #22: *For individuals whose primary/preferred language is not English,*

there is documentation that the psychologist has endeavored to assess them in their own language.

#23: *If this is not possible, there is a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.*

	May	Jun	Jul	Mean
N	36	32	45	
n	2	2	2	
%S	6	6	4	
%C				
%C-#22	0	100	100	67
%C-#23	0	100	100	67

This monitor reviewed 12 charts (LP, NV, RR, LAJ, OM, QHV, HMT, FG, CMW, GD, FL, and SFY) of individuals whose primary and or preferred language is not English. LP, who is Spanish-speaking, was assessed in English with a decision to conduct future assessments in Spanish. There is no indication that this was accomplished. Six individuals (OM, FG, QHV, FL, CMW, and GD) were assessed through interpreters, or waiting to be assessed through interpreters. Three individuals (NV, RR, and LAJ) were said to be able to function in English. SFY speaks Cantonese and was assessed by a Cantonese-speaking examiner, and documentation states that SFY can understand some English and can comprehend enough to participate in PSR Mall groups. HMT is an Arabic speaker who has been in USA for the last 20 years and prefers to converse in English.

Compliance:
Partial.

		Current recommendations: 1. Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Carmen Fayloga, RN/HSS 2. Joellyn Arce, NC in Central Nursing Services 3. Aurora Hendricks, CNS Reviewed: 1. Draft of statewide Nursing Admission Assessment form 2. Draft of Integrated Nursing Assessment form 3. Lesson Plans for Nursing Assessment, Plan of Care and Wellness and Recovery Model 4. Staff training rosters for Recovery 5. Self Assessment Survey for Psychiatric Nursing Skills form and data 6. Nursing Education training schedule regarding Management of Common Psychiatric Disorders and Interventions Across Disorders 7. Therapeutic Milieu Observation Monitoring instrument and instructions 8. Nursing Assessment Competency Validation instrument and instructions 9. RN Competency validation log 2007 10. License verification data for May, June, and July 2007 11. MSH's progress report and data 12. Medical records for the following 30 individuals: CJ, JM, DW, RR, JB, SH, CK, LO, ES, JG, SG, JP, TC, DM, TM, RO, JJ, IC, ME, PL, MM, MB, AE, JU, FK, GK, JE, SV, KA, HQ Observed: 1. Shift report on Unit 410 2. Individuals on Unit 419

<table>
<tr><td>D.3.a</td><td>Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:</td><td>Compliance:
Partial.</td></tr>
<tr><td>D.3.a.i</td><td>a description of presenting conditions;</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Ensure that the Admission Nursing Assessment is reflective of the Wellness and Recovery Model and aligned with the EP.

Findings:
The Statewide Nursing Committee has developed an Admission Nursing Assessment and Integrated Assessment based on the Wellness and Recovery Model. The draft of the admission assessment that I reviewed was very comprehensive and should effectively add to nursing's movement from a limited scope of practice to an expanded Wellness and Recovery focus. Finalizing and implementation of the assessment should take place within the next few months.

Recommendation 2, March 2007:
Continue to monitor this requirement.

Findings:

The following tables summarize MSH's compliance data regarding admission assessments (N) and each item for this requirement from the EP:

Admission Nursing Assessment Monitoring Form
<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N = total number of admissions each month</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
</table>
</td></tr>
</table>

n = actual number of audits completed	22	25	36	30	34	
%S	58	61	100	94	75	
Compliance rate: #2: Is there a description of the presenting conditions?	100	100	92	96	97	97

From my review of 30 individuals' admission assessments (CJ, JM, DW, RR, JB, SH, CK, LO, ES, JG, SG, JP, TC, DM, TM, RO, JJ, IC, ME, PL, MM, MB, AE, JU, FK, GK, JE, SV, KA, HQ), I found that overall the presenting complaints were detailed and specific to the individual. Allergies, pain, use of assistive devices, activities of daily living, immediate alerts, and conditions needing immediate nursing interventions were adequately addressed on all 30 assessments. Vital signs were obtained on all the assessments. However, blood pressures were only obtained from the left arm and documented as refused for the right arm on all 30 assessments. After discussion with Nursing, it was decided that the facility would evaluate if blood pressures in each arm are required and if so, ensure that they are being consistently obtained. In addition, all of the assessments addressed currently prescribed medications, but 29 did not address the last time the individual took their medications as specified in the directions of the assessment and the monitoring instrument. This is the only item for which my findings did not support the compliance scores from the facility. From my discussion with Nursing, the newly developed Nursing Admission Assessment will specifically require a response regarding when the last dose of medication was taken, which will correct this deficiency.

Current recommendations:

1. Implement the Statewide Nursing Admission Assessment and Integrated Assessment forms.
2. Continue to monitor these requirements.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>D.3.a.ii</td><td>current prescribed medications;</td><td>(information inadvertently deleted; will be reviewed in next report)</td></tr>
<tr><td>D.3.a.iii</td><td>vital signs;</td><td>Admission Nursing Assessment Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of admissions each month</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>22</td><td>25</td><td>36</td><td>30</td><td>34</td><td></td></tr>
<tr><td>%S</td><td>58</td><td>61</td><td>100</td><td>94</td><td>75</td><td></td></tr>
<tr><td>%C
#4 Vital signs are documented.</td><td>100</td><td>100</td><td>100</td><td>100</td><td>97</td><td>99</td></tr>
</table></td></tr>
<tr><td>D.3.a.iv</td><td>allergies;</td><td>Admission Nursing Assessment Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of admissions each month</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>22</td><td>25</td><td>36</td><td>30</td><td>34</td><td></td></tr>
<tr><td>%S</td><td>58</td><td>61</td><td>100</td><td>94</td><td>75</td><td></td></tr>
<tr><td>%C
#5 Are allergies identified?</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table></td></tr>
<tr><td>D.3.a.v</td><td>pain;</td><td>Admission Nursing Assessment Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of admissions each month</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>22</td><td>25</td><td>36</td><td>30</td><td>34</td><td></td></tr>
<tr><td>%S</td><td>58</td><td>61</td><td>100</td><td>94</td><td>75</td><td></td></tr>
<tr><td>%C
#6 Is the Pain Assessment completed</td><td>100</td><td>96</td><td>100</td><td>96</td><td>97</td><td>98</td></tr>
</table></td></tr>
</table>

		per hospital policy? | | | | | | | |
D.3.a.vi	use of assistive devices;	**Admission Nursing Assessment Monitoring Form** N = total number of admissions each month: Mar 38, Apr 41, May 36, Jun 32, Jul 45 n = actual number of audits completed: Mar 22, Apr 25, May 36, Jun 30, Jul 34 %S: Mar 58, Apr 61, May 100, Jun 94, Jul 75 %C #7 Is the use of assistive devices addressed?: Mar 100, Apr 100, May 100, Jun 100, Jul 100, Mean 100
D.3.a.vii	activities of daily living;	**Admission Nursing Assessment Monitoring Form** N = total number of admissions each month: Mar 38, Apr 41, May 36, Jun 32, Jul 45 n = actual number of audits completed: Mar 22, Apr 25, May 36, Jun 30, Jul 34 %S: Mar 58, Apr 61, May 100, Jun 94, Jul 75 %C #8 Are Activities of Daily Living addressed?: Mar 100, Apr 100, May 100, Jun 100, Jul 100, Mean 100
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	**Admission Nursing Assessment Monitoring Form** N = total number of admissions each month: Mar 38, Apr 41, May 36, Jun 32, Jul 45 n = actual number of audits completed: Mar 22, Apr 25, May 36, Jun 30, Jul 34 %S: Mar 58, Apr 61, May 100, Jun 94, Jul 75 %C

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>#9 Is the identified immediate alert(s) defined within the body of the Nursing Assessment (e.g., escape risk, physical assault, choking risk, suicidal risk, homicidal risk, fall risk, sexual assault, self-injurious behavior, arson or fire setting)?</td><td>86</td><td>92</td><td>92</td><td>100</td><td>96</td><td>93</td></tr>
</table>
</td></tr>
<tr><td>D.3.a.ix</td><td>conditions needing immediate nursing interventions.</td><td>
Admission Nursing Assessment Monitoring Form
<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N = total number of admissions each month</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>22</td><td>25</td><td>36</td><td>30</td><td>34</td><td></td></tr>
<tr><td>%S</td><td>58</td><td>61</td><td>100</td><td>94</td><td>75</td><td></td></tr>
<tr><td>%C
#10 Documentation describe conditions needing immediate nursing interventions.</td><td>100</td><td>100</td><td>86</td><td>100</td><td>94</td><td>96</td></tr>
</table>
</td></tr>
<tr><td>D.3.b</td><td>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</td><td>
Current findings on previous recommendations:

Recommendation 1, March 2007:
Continue to integrate the Wellness and Recovery principles and language into nursing practice at MSH.

Findings:
MSH has made significant efforts to integrate Wellness and Recovery principles and language into nursing practices since my last review. From my review and discussion with Nursing, the training has been ongoing for regarding the Statewide Wellness and Recovery Plan
</td></tr>
</table>

		Manual and integration of these principles and language into the Nursing Education curriculum for application in nursing practice. In addition, the Nursing Duty Statements are being revised to reflect performance of nursing practice applying principles of Wellness and Recovery. Also, nursing is revising the nursing staff's Individual Development Plans to reflect evaluation of performance in applying principles of Wellness and Recovery. **Recommendation 2, March 2007:** Provide training regarding psychiatric nursing principles and practice to nurses who do not have a psychiatric background. **Findings:** To address this recommendation, the Nursing Education Department at MSH developed a Self-Assessment Survey on Psychiatric Nursing Skills. The survey data were used to assess the educational and training needs of nurses who do not have a psychiatric background. Of 192 RNs and LVNs, 89% were surveyed using the Self-Assessment Survey Form. From the data below, specific curricula are being developed in the areas where there is an identified need. Training will begin in September 2007. Level of Skill/Experience: Level 1 – less than 6 months experience Level 2 – 6 months – 1 year experience Level 3 – 1-3 years experience Level 4 – more than 3 years experience

Self Assessment Survey on Psychiatric Nursing Skills

Skill/Experience	Level 1 (%)	Level 2 (%)	Level 3 (%)	Level 4 (%)	Total %
1. Therapeutic Communication Skills	4	3	8	85	100
2. Admission of a Psychiatric Individual	10	9	9	72	100
3. Neurological Check and Assessment	3	3	6	88	100
4. Care of the Ind. in Psychiatric/Mental Health Facility	4	2	5	89	100
5. Care of the Ind. with ADD/ADHD	24	9	15	52	100
6. Care of the Ind. with Alzheimer's	16	7	11	66	100
7. Care of the Ind. with Schizophrenia	2	4	6	88	100
8. Care of the Ind. with Personality Disorders, including Borderline	6	4	8	82	100
9. Care of the Individual with Mood Disorders, including Bipolar	4	4	6	86	100
10. Care of the Ind. with Depressive Symptoms	3	4	5	88	100
11. Care of the Ind. with Psychotic Symptoms	3	4	6	87	100
12. Care of the Ind. with Assaultive Behavior	4	4	7	85	100
13. Care of the Ind. with Suicidal Ideation/Attempt	4	4	5	87	100
14. Leading Groups/Group Process Skills	15	12	17	56	100

15. Behavioral Documentation	5	5	6	84	100

Recommendation 3, March 2007:
Develop and implement strategies and interventions to assist the nursing staff in developing therapeutic relationships with the individuals in order to effectively execute Wellness and Recovery.

Findings:
The following table summarizes MSH's data regarding nurse interactions on the units using the Therapeutic Milieu Observation Monitoring Form. Although modules on Therapeutic Milieu are integrated in the Nursing Education Curriculum during orientation, the data indicates that additional strategies and interventions such as mentoring programs should be implemented to augment and reinforce the initial orientation training.

Therapeutic Milieu Observation Monitoring Form
(Data Reflects Nursing Staff Only)

	Mar	Apr	May	Jun	Jul	Mean
N = total number of Units	17	17	17	17	17	
n = actual number of Units audited/observed	10	10	10	10	9	
%S	56	56	56	56	53	
%C						
#1 More staff are in the Milieu than in the nursing station.	90	100	90	100	100	96
#2 Staff in the Milieu are interacting with Individuals, not simply observing them.	90	90	100	100	100	96
#3 There are unit recognition programs.	78	80	70	60	67	71
#4 Positive affirmations	50	70	70	80	67	67

		about recovery and hope are posted throughout the unit.							
		#5 Unit rules are posted and reflect recovery language and principles.	70	90	70	60	78	74	
		#6 Unit bulletin boards are posted with religious/cultural activities.	70	70	40	60	78	64	
		#7 Staff respect confidentiality.	80	80	100	90	100	90	
		#8 Staff are observed offering praise or positive feedback to Individuals.	90	100	90	90	89	92	
		#9 Staff are heard acknowledging Individuals' strengths and abilities.	80	80	80	80	78	80	
		#10 Staff are observed responding appropriately to Individuals' requests for assistance.	100	100	100	100	89	98	
		#11 Staff are observed offering choices to Individuals.	90	90	90	70	56	79	
		#12 Staff are observed discussing mall activities with Individuals.	50	30	50	X	67	49	
		#13 Staff use label-free language.	80	90	80	80	89	84	
		#14 Staff makes use of language and terms used in Recovery Training.	50	90	70	80	89	76	
		#15 Staff are actively engaged in listening.	100	100	100	100	100	100	

<table>
<tr>
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<table>
<tr><td>#16 Staff interact with Individuals in a respectful and courteous manner.</td><td>100</td><td>100</td><td>90</td><td>100</td><td>100</td><td>98</td></tr>
<tr><td>#17 Staff encourages Individuals to help each other.</td><td>30</td><td>70</td><td>40</td><td>50</td><td>56</td><td>49</td></tr>
<tr><td>#18 Staff encourages Individuals to interact with each other.</td><td>60</td><td>40</td><td>40</td><td>30</td><td>56</td><td>45</td></tr>
<tr><td>#19 Staff react calmly in escalating situations.</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>#20 Staff are observed using “Conflict Resolution” principles and techniques.</td><td>100</td><td>100</td><td>100</td><td>67</td><td>100</td><td>93</td></tr>
<tr><td>#21 Staff respect privacy.</td><td>100</td><td>100</td><td>100</td><td>100</td><td>22</td><td>84</td></tr>
<tr><td>#22 Property checks occur with respect.</td><td>X</td><td>X</td><td>100</td><td>X</td><td>X</td><td>100</td></tr>
<tr><td>#23 Staff know Individuals’ Wellness and Recovery Plans.</td><td>40</td><td>70</td><td>60</td><td>40</td><td>67</td><td>55</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Continue efforts to integrate Wellness and Recovery into nursing practices.
2. Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.3.c</td>
<td>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Continue to develop and implement a monitoring system to address this requirement.</td>
</tr>
</table>

Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.

Findings:
MSH developed the Nursing Assessment Competency Validation Form in February 2007 addressing this recommendation. Initial data collection was implemented in March 2007. Data for April and May was not collected. The audit resumed in June and July and will be conducted monthly. The table below summarizes MSH's data regarding nursing competency performing admission assessments. MSH needs to expand this instrument to include competency data regarding other nursing assessments such as acute illness and injuries.

Nursing Assessment Competency Validation Form

	Mar	Apr	May	Jun	Jul	Mean
N = total number of RNs	112	113	114	116	116	
n =total number of audits completed	10	X	X	23	21	
%S	9	X	X	20	18	
Compliance rates						
#1: Is the Assessment completed within the required time frame, e.g., 24 hours, 7 days, quarterly, or annually?	90	X	X	100	100	97
#2: Is the Individual's Presenting Conditions assessed and documented?	90	X	X	100	100	97
#3: Are all Current Prescribed Medications documented?	71	X	X	100	100	90
#4: Are all Vital Signs complete and documented?	75	X	X	90	100	88
#5: Are Allergies identified and	67	X	X	100	100	89

documented?								
#6: Is the Pain Assessment completed per hospital policy?	100	X	X	100	100	100		
#7: Is the use of Assistive Devices assessed and documented?	100	X	X	100	100	100		
#8: Are Activities of Daily Living assessed and documented?	100	X	X	100	100	100		
#9: Are all Identified Alerts addressed (escape risk, physical assault, choking risk, suicidal risk, homicidal risk, fall risk, sexual assault, self-injurious behavior, arson or fire setting)?	100	X	X	100	100	100		
#10: Is there documentation describing conditions needing immediate nursing interventions?	100	X	X	75	88	88		

Recommendation 2, March 2007:
Ensure that there is a reliable system for monitoring and tracking nursing licenses and renewals.

Findings:
MSH's has a reliable computerized tracking system regarding validation for current licensure. In addition, hard copies of nursing staff licenses are kept in the Nursing Department. The California Board license internet site is checked for initial license verification and for renewals.

<table>
<tr>
<td></td>
<td></td>
<td>The following table summarizes the facility's data regarding the number of nurses (N) and compliance with licensure verification.

No. of Nurses With Current CA RN License
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>X</td><td>X</td><td>198</td><td>198</td><td>203</td><td></td></tr>
<tr><td>n</td><td>X</td><td>X</td><td>198</td><td>198</td><td>203</td><td></td></tr>
<tr><td>%S</td><td>X</td><td>X</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C</td><td>X</td><td>X</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>
Recommendation 3, March 2007:
Continue to monitor this requirement.

Findings:
Same as above.

Compliance:
Partial.

Current recommendations:
1. Develop and implement a system to ensure nursing competency regarding assessments for acute illness and injuries.
2. Continue to monitor this requirement.</td>
</tr>
<tr>
<td>D.3.d</td>
<td>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</td>
<td>Compliance:
Partial.</td>
</tr>
<tr>
<td>D.3.d.i</td>
<td>Initial nursing assessments are completed within 24 hours of the individual's admission;</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Continue testing for reliability until acceptable percentage of agreement (85% or higher) is achieved.</td>
</tr>
</table>

Findings:
Inter-rater reliability testing was conducted once a month among the designated auditors until an acceptable percentage of agreement was achieved (85% or higher). The table below illustrates MSH's data regarding inter-rater reliability.

Inter-Rater Reliability (Agreement Among Pairs of Auditors)

Monitoring Form	Month	n (no. of pairs)	Mean % Agreement
Admission Nsg. Assessment	March	12	58
Admission Nsg. Assessment	April	6	58
Admission Nsg. Assessment	May	1	80
Admission Nsg. Assessment	June	2	85

Recommendation 2, March 2007:
Continue to monitor this requirement.

Findings:
The table below summarizes MSH's compliance data regarding timeliness (within 24 hours) of completion for nursing admission assessment.

Admission Nursing Assessment Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = total number of admissions each month	38	41	36	32	45	
n = actual number of audits completed	22	25	36	30	34	
%S	58	61	100	94	75	
%C #1 Initial Admission Nursing Assessment is completed within 24	100	100	94	100	97	98

<table>
<tr>
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<table>
<tr><td>hours of the Individual's admission.</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

From my review of 30 nursing admission assessments (CJ, JM, DW, RR, JB, SH, CK, LO, ES, JG, SG, JP, TC, DM, TM, RO, JJ, IC, ME, PL, MM, MB, AE, JU, FK, GK, JE, SV, KA, HQ), I found that all 30 were completed within 24 hours of the individual's admission to the facility.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.3.d.ii</td>
<td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
The table below summarizes MSH's compliance data regarding completion of the Integrated Nursing Assessment within 7 days of admission.

Nursing Assessment Monitoring Form
(7-Day)
<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N = total number of admissions each month</td><td>38</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>26</td><td>27</td><td>36</td><td>27</td><td>23</td><td></td></tr>
<tr><td>%S</td><td>68</td><td>66</td><td>100</td><td>84</td><td>51</td><td></td></tr>
<tr><td>%C
#1 Is the Integrated Nursing Assessment completed within 7 days of the Individual's</td><td>58</td><td>59</td><td>80</td><td>67</td><td>83</td><td>69</td></tr>
</table>
</td>
</tr>
</table>

		admission? | | | | | | | | From my review of 17 Integrated Assessments (JM, CK, SG, CJ, JB, JP, RO, TC, JJ, LO, ES, JG, IC, ME, SH, RR, DW), five (JB, JP, LO, SH, RR) were not completed within the required timeframes. **Current recommendation:** Continue to monitor this requirement.
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** The compliance data provided by MSH combined the 14-day, 30-day, and annual reviews and was not able to be accurately interpreted. However, from my discussion with Nursing, compliance regarding this requirement is significantly low due to issues regarding the timeliness of the conferences, staffing vacancies, scheduling conflicts, and increased tasks assigned to Consistent and Enduring Team (CET) members. A process has been implemented to streamline the WRP scheduling process and notify Program Managers of WRP cancellations for appropriate follow-up. **Current recommendations**: 1. Ensure that nursing assessments are reviewed as required by the EP. 2. Separate data for each element of this requirement. 3. Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Rebecca McClary, Chief of Rehabilitation Services 2. Keisha Foster, Speech Therapist 3. Julia Hastings, Physical Therapist 4. Joanna Cooper, Speech Therapist 5. Yvette Troncoso, Rehabilitation Monitor 6. Andrea Cirota, Rehabilitation Monitor 7. Asha Vij, Occupational Therapist 8. Adella Davis-Sterling, Supervising Registered Nurse 9. Portia Salvacion, Assistant Director of Dietetics 10. Julie Duane, PNMP Team leader 11. Aurora Hendricks, CNS 12. Marilu Tiberi Vipraio, Assistant Chief of Central Program Services 13. Marion Palcibar, Physical Therapist 14. Willie Smith, Recreation Therapist 15. Wanda Wullschleger, Recreation Therapist Reviewed: 1. MSH Rehabilitation Therapy Manual 2. Integrated Rehabilitation Therapy Assessment (IRTA) 3. Integrated Rehabilitation Therapy Assessment instructions 4. DMH Rehabilitation Therapy Audit 5. DMH Rehabilitation Therapy Audit instructions 6. DMH Rehabilitation Audit data 7. MSH AD 1052 Procedure for Physical, Occupational, and Speech Therapy 8. Vocational Services Self Assessment audit data 8/07 9. Rehabilitation Screening II tool 10. Joint Mobility Assessment tool 11. MSH Speech and Language Screening tool

		12. MSH Speech and Language Dysphagia Screening tool 13. MSH Speech and Language Pathology Cognitive Screen/Evaluation tool 14. MSH Physical Therapy Evaluation 15. Comprehensive Team Assessment for Physical and Nutritional Support 16. Industrial Therapy Request for Evaluation and Treatment 17. MSH Work Training Assessment 18. Work Activities weekly note template 19. Comprehensive Vocational Assessment template sample 20. Finalized IRTA training attendance/signature sheets 21. Physical/Occupational/Speech Therapy Training Manual 22. Mobility Assessment database for July and August 2007 23. List of members on current Physical and Nutritional Support Team 24. Physical Nutritional Support Team Meeting minutes and attendance sheets from 4/16/07, 4/30/07, 5/5/07, 5/14/07 25. Physical and Nutritional Support Team Training Agenda and attendance sheets for 6/4/07, 6/5/07, 6/6/07, 6/7/07 26. Physical Nutritional Management team roles 27. Physical and Nutritional Support Plan template 28. Dining Plan template 29. Choking/Aspiration Post-Incident Evaluation 30. List of individuals who have had an Integrated Rehabilitation Therapy Assessment in the past three months 31. Records of the following individuals who have had Integrated Rehabilitation Assessments in the past three months: PQ, TP, RU, TO, JD, CG, JW, MW, MM, CJ, NP, JM, EC 32. List of individuals who have had Occupational Therapy assessment/consultation in the past six months 33. Assessments and corresponding WRPs of the following individuals who have had Occupational Therapy assessment/consultation in the past six months: RW, CS, TP, LP, AL 34. List of individuals who have had Physical Therapy

		assessment/consultation in the past six months 35. Assessments and corresponding WRPs for the following individuals who have had Physical Therapy assessment/consultation in the last six months: GF, RP, LP, RM, CG, RC, MM, JM, FJ, HF, AL 36. List of individuals who have had Speech Therapy assessment/consultation in the past six months 37. Assessments and corresponding WRPs for the following individuals who have had Speech Therapy assessment/consultation in the last six months: RW, PQ, HT, MG, TM, DR 38. Vocational Assessments and corresponding WRPs for the following individuals who have had a Vocational Assessment in the last six months: RB, OG, JT, LR, MM, BM, AC, LM 39. List of individuals who have had Comprehensive Assessment for Physical and Nutritional Management in the past six months 40. Comprehensive Assessment for Physical and Nutritional Management for the following individuals: LP, AH, RS, TP 41. Rehab Therapy Inter-rater Reliability Study May 2007 42. Quarterly Qualitative Profile for Rehab Assessment for 2007 43. PNMP Overview Training curriculum 44. Dysphagia Training and corresponding Post-test 45. Positioning Competency-based Training Checklist 46. Mealtime Competency-based Training Checklist
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue the process of integrating OT, PT, and Speech Therapy into the Rehabilitation Therapy Services. **Findings:** This recommendation has not been met, though some progress has been made. The Integrated Rehabilitation Therapy Assessment, instructions and audit tool/instructions have been updated to include a section for

		Occupational, Physical, and Speech Therapy referral, and an informal plan is in place to meet as one department beginning in September. The current Physical Nutritional Support Team is interdisciplinary, though this does not meet the requirements of this recommendation, as the members of the team include OT, PT, SLP, Registered Dietitian, and Registered Nurse, with no collaboration/integration among Rehabilitation Services department disciplines. Upon review of the MSH Rehabilitation Therapy Manual, it was noted that the following procedures did not provide evidence of inclusion/integration of Physical Therapy, Speech Therapy or Vocational Rehabilitation/Industrial Therapy: 1. Rehabilitation Therapy Services Definition, Goals, and Objectives; 2. Philosophy of Rehabilitation Therapy; 3. General Terminology; and 4. Mall Progress Notes. Information in the current procedure for Rehabilitation Therapy Integration is brief and the procedure itself appears to be redundant, as the content should be incorporated into existing procedures to illustrate evidence of an integrated department. The Organizational Chart in the Rehabilitation Services Manual does not currently reflect integration between Physical and Psychosocial Rehabilitation therapists. Upon interview and review of procedures, it does not appear that formal integration of Physical, Occupational, and Speech Therapy into the Rehabilitation Services department, as evidenced by practice, is occurring at this time. The department would benefit from restructuring to ensure collaboration and integration of Psychosocial Rehabilitation professionals (Art, Music, Dance/Movement, and Recreation Therapists), Physical Rehabilitation professionals (Occupational, Physical, and Speech Therapists), and Vocational Rehabilitation/Industrial Therapy.

		Recommendation 2, March 2007: Review completed Integrated Rehabilitation Therapy Assessments to ensure that they are comprehensive and yield meaningful outcomes related to the individuals' Wellness and Recovery goals and objectives. **Findings:** The Integrated Rehabilitation Therapy Assessment and instructions and audit tool and instructions were revised and implemented on August 1, 2007. Interview with Rehabilitation Chief indicated that IRTA audits have been completed by two supervising Rehabilitation Therapist monitors, with 95% inter-rater reliability established during May 2007 based on a 16-chart sample. According to facility report, 177 charts were audited between March and July 2007. IRTA audit data from March to July was provided to this monitor, in a complete table, and in fragmented portions of audit data tables. The data sources appeared to give conflicting data, and the data in the partial tables was difficult to interpret. Thus, all data reported by this monitor has been taken from the progress report audit data provided in D.4.a. of the August 2007 MSH progress report. In practice, the current audit tool is designed to capture documentation compliance, and does not monitor for quality and accuracy of assessment findings or clinical appropriateness of outcomes/objectives. It appears that a smaller sample size of IRTA audits with more focus on thorough qualitative analysis would be more beneficial in ensuring that IRTAs meet/exceed generally accepted professional standards of care. **Recommendation 3, March 2007:** Continue to revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement.

		Findings: The current protocol for Integrated Rehabilitation Therapy Assessments states that annual assessments are to be completed on the anniversary month of admission. However, the Wellness and Recovery system and Enhancement Plan does not require annual assessments by Rehabilitation Therapy; assessment data is updated as needed during WRPCs and upon WRPT referral. The protocol should be revised to reflect this practice. Upon review of the Rehabilitation Therapy Manual, it was noted that there was no policy/procedure outlining the department's vision and organizational structure as an integrated unit, with all disciplines represented. Individual protocols reviewed are fragmented and do not provide a global and integrated depiction of the structure and function of the Rehabilitation Services department as a whole. Vocational Rehabilitation/Industrial Therapy Services is not currently incorporated into the Rehabilitation Therapy department. The Physical, Occupational, and Speech Therapy procedure (AD 1052) lists general content required in Physical, Occupational and Speech Therapy assessments/consultations, and states that referrals are to be answered within 24 hours and completed within 48 hours. The procedure states that referrals can be made to Occupational, Physical, and Speech Therapy for Evaluation and Recommendation, and to Occupational and Physical Therapy for Request for Specific Treatment. Request for Specific Treatment referrals include determination by the physician as to the type, duration, and frequency of Physical and Occupational Therapy treatment/modalities. The procedure does not specify whether this type of referral is done following PT or OT evaluation and recommendation or in lieu of evaluation, but should be clarified to ensure that the specific treatment requested is clinically appropriate for each individual as evidenced by PT/OT evaluation findings.

		Currently, there are no specific protocols written or implemented for instructions to accompany the Comprehensive Team Assessment for Physical and Nutritional Management, Vocational Rehabilitation assessment, or Occupational, Physical, or Speech Therapy assessments done in response to referral/consultation to ensure quality and comprehensiveness. Physical, Speech and Occupational Therapy Assessments, Comprehensive Assessments, and Vocational Rehabilitation assessments are not consistent with corresponding assessments at the other three state hospitals. **Recommendation 4, March 2007:** Ensure that the monitoring system addresses all of the elements of this requirement. **Findings:** There are no protocols written or in place for Physical Therapy, Occupational Therapy, Speech Therapy, Comprehensive Team Assessment for Physical Nutritional Support, or Vocational Services Assessment audits. There is a system in place to document timeliness of Occupational, Physical, and Speech Therapy assessments and consultation response, as well as informally list therapy objectives, though there is no audit tool in place to assess for quality of content. There is no formal protocol in place to describe this process and responsible parties, though it is reported at this time that this information is recorded by the Nursing Supervisor. **Recommendation 5, March 2007:** Review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language and departmental, administrative, and system changes.

		Findings: In order to ensure an integrated Rehabilitation Services department, the existing Physical, Speech, and Occupational Therapy manuals/procedures should be incorporated into the Rehabilitation Therapy Manual, which should include Wellness and Recovery language. Thus, findings for this recommendation will not be addressed separately. **Other findings:** Currently, the Integrated Rehabilitation Therapy Assessment is performed by one assigned therapist within the Rehabilitation services department, which may be an Art, Music, Dance/Movement, or Recreation Therapist. Therapists are not currently grouped into teams to administer the initial assessment and perform clinical analysis of findings in an integrated format. While the assessment shell appears integrated in functional content, it is not currently an integrated assessment in practice. The Integrated Rehabilitation Therapy Assessment findings are determined primarily by chart review and interview, with no evidence of findings derived from administered structured assessment activities and clinical observation. It does not appear that the clinical expertise of the Rehabilitation Therapists is being utilized, as the therapists are not currently performing a true assessment, but rather are gathering data and using the assessment shell as a screening tool. The Integrated Rehabilitation Therapy Assessment instructions do not specify or require the use of clinically appropriate assessment activities to determine findings to ensure a Rehabilitation Therapy focus/perspective. Currently, there are no narrative sections within the IRTA to allow for documentation of clinical analysis of assessment findings. While the Integrated Rehabilitation Therapy Assessment contains a

		section for referrals for Occupational Therapy, Physical Therapy, Speech Therapy, Audiologist, Dietitian, Vocational Rehabilitation, and Optometrist evaluations, there is no instruction for focused assessments done by Rehabilitation Therapy professionals or for Comprehensive Physical Rehabilitation assessments. The Comprehensive Team Assessment for Physical and Nutritional Support is currently administered upon referral for individuals with dysphagia (with priority for Level 1 dysphagia). The assessment is interdisciplinary in format but upon review of tools and interviews, it does not appear to be collaborative. While Nursing and Nutrition assessment data is included in the overall assessment, it appears that this data is duplicative of the standard Nursing and Nutrition assessments, with no true integration noted. The current assessment appears to be structured to meet the needs of a developmental disability target population, rather than address acute and chronic rehabilitation therapy needs of individuals within an inpatient psychiatric facility. The current Comprehensive Team Assessment for Physical and Nutritional Support is appropriate to meet the needs of individuals with dysphagia, but is not comprehensive enough at this time to meet the rehabilitation therapy needs of individuals across functional domains. The Physical Nutritional Support Team concept does not appear to be a good fit for an inpatient psychiatric rehabilitation facility. The comprehensive physical rehabilitation needs of the facility would be appropriately addressed with teams comprised of an Occupational, Physical, and Speech therapist, which would collaborate with the WRPT and specific professionals (e.g., Nurse, Dietitian) as clinically necessary and indicated on an individualized basis. Upon review of Speech Therapy assessments, it was noted that

		assessment formats were inconsistent, and often not comprehensive enough, particularly in regards to analysis of findings. Drafts of proposed assessment protocols were reviewed, and should continue to be developed. Currently, it appears that no standardized assessment tools/batteries are used for Speech Language Pathology evaluation. Upon review of the Physical Therapy assessments, it is noted that assessments are not consistent in format, and are brief and based primarily on quantitative findings, with minimal focus on documentation of narrative findings related to qualitative clinical observations and function (e.g., quality of movement, daily activities affected by pain). No consistent protocol for Physical Therapy assessments has been developed or implemented. Upon review of the Occupational Therapy assessments, it is noted that assessments are not consistent in format, and most are written in a brief narrative format in response to consultation. No comprehensive and consistent format and protocol for Occupational Therapy assessments has been developed or implemented. The assessment process for Vocational Rehabilitation currently includes the following components: Vocational referral form from the WRP, MSH Work Training Assessment, and Vocational Interest Survey. The Vocational Interest Survey is done by teachers for special education students and adolescents. There is not a protocol in place that describes the documentation requirements and time frames for this process. The current Assistant Chief of Central Program Services who supervises the Vocational Rehabilitation/Industrial Therapy program does not believe that the current system for assessment is adequate to meet the needs of MSH individuals. She has proposed an informal plan by which each new admission to MSH will have an initial screening, followed by a standardized/norm referenced comprehensive assessment as needed such as the Vocational Career Aptitude Test,

		Career Zone (Internet-based tool), or the California Assessment Standards for Adult Students. **Compliance:** Partial. **Current recommendations**: 1. Revise and implement organizational structure of Rehabilitation Services Department to include Psychosocial Rehabilitation (Music, Dance/Movement, Art, and Recreation Therapy), Physical Rehabilitation (Occupational, Physical, and Speech Therapy), and Vocational Rehabilitation/Industrial Therapy. 2. Revise and implement Rehabilitation Therapy Manual to reflect changes including departmental integration and re-structuring, as well as a description of all Rehabilitation Therapy disciplines, collaboration among disciplines and therapy teams, the departments' unified role in the WRP team process, and discipline-specific responsibilities in the team process. 3. Revise and implement Integrated Rehabilitation Therapy Assessment and instructions to ensure interdisciplinary assessment by a Psychosocial Rehabilitation Team for all admission assessments, with clinical assessment activities and analysis of findings incorporated into the IRTA process. 4. Develop and implement Rehabilitation Therapy protocols/ instruction sheets for Vocational Rehabilitation, Physical Therapy, Speech Therapy, and Occupational Therapy assessments. 5. Discontinue the Physical Nutritional Support Team, Comprehensive Assessment for Physical and Nutritional Support, and corresponding procedures. Develop and implement procedure for the provision of two interdisciplinary Physical Rehabilitation teams (POST), each comprised of a Physical, Occupational, and Speech Therapist, to replace the existing Physical Nutritional Support Team.

		6. Develop and implement Comprehensive Integrated Physical Rehabilitation Assessment to address individual needs and supports that include but extend beyond the scope of dysphagia management, and ensure that this assessment is appropriate for use in measuring function and assessing acute and chronic physical rehabilitation needs of individuals within the inpatient Psychiatric Rehabilitation population. 7. Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Integrated Rehabilitation Assessment are referred for this service by the WRP. 8. Develop and implement Comprehensive Integrated Rehabilitation Assessment instructions.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs. **Findings:** See F.4 for findings regarding interventions for individuals with Occupational, Physical, and Speech Therapy needs. **Recommendation 2, March 2007:** Ensure that OT, PT, and Speech Therapy assessments and interventions are integrated into the individuals' WRPs.

		Findings: See F.4 for findings regarding this recommendation. **Recommendation 3, March 2007:** Continue to assess and develop 24-hour, proactive interventions for individuals who are at risk or are at high risk for choking and aspiration. **Findings:** According to facility report, six individuals are currently at Level 1 risk for dysphagia, and 35 individuals are at Level 2 risk. Sixteen of these individuals have had a Dining Plan (in the format specified by procedure) implemented to provide 24-hour support to help to prevent aspiration/choking, and 75% had assessments done prior to Dining Plan implementation. According to facility report, 25% of Dining Plans were written by consultants and implemented without comprehensive assessments being completed by the PNMP team. According to procedure, the Choking/Aspiration Post Incident Evaluation is completed following incident, and sent to Medical Services within two hours. **Recommendation 4, March 2007:** Continue to provide ongoing training to all team members regarding dysphagia. **Findings:** Dysphagia Training Curriculum, a Managing Dysphagia post-test, and signature sheets were provided to this monitor. However, no evidence of competency-based training was documented, and minimum scores/ actual scores/achievement of compliance were not listed in the provided documentation. According to facility report, a 4-day Physical Nutritional Management Training was provided to 32 Physical Nutritional Management Planning team members in June 2007. Training

		was provided to 163 WRPT members on 6/26/06 and 6/28/07, training was provided to physicians on 8/15/07, and a training video has been made for future use. Dysphagia training is currently being provided in New Employee Orientation and with annual Nursing Updates. **Recommendation 5, March 2007:** Ensure that mobility assessments and fabrication of wheelchairs to promote appropriate body alignment for individuals are conducted in collaboration with members of the WRP team. **Findings:** According to the Medical Services Wheel Chair Log Tracking database, 19 individuals have had orders for Mobility Assessments, and 74% had completed assessment dates listed. No evidence of these follow-up assessments was provided to this monitor. Currently, Physical Therapy Assessments are requested by the WRPT, but there is no means by which the WRPT can request an integrated Physical, Occupational, and Speech Therapy team assessment to address mobility/alignment issues related to function (e.g., self-care skills, communication, eating) concerns if clinically appropriate. **Recommendation 6, March 2007:** Continue to work on streamlining the process of obtaining adaptive equipment. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 7, March 2007:** Continue to provide and document training to individuals and staff regarding the appropriate use of adaptive equipment.

		Findings: See section F.4 for findings regarding this recommendation. **Recommendation 8, March 2007:** Develop a monitoring system to ensure that individuals have access to their adaptive equipment and that it is in proper working condition, and that it is being used appropriately. **Findings:** See section F.4 for findings regarding this recommendation. **Recommendation 9, March 2007:** Continue to re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. **Findings:** See section F.4 for findings regarding this recommendation. **Recommendation 10, March 2007:** Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. **Findings:** There is no current formal plan to address this recommendation. However, it appears that the WRP system is sufficient to address this recommendation and make appropriate referrals to Rehabilitation Services discipline(s) for individuals requiring these services. According to facility report, one individual has been identified as legally blind and uses a cane for mobility, and 15 individuals currently use hearing aids. See F.4 for findings regarding implementation and

		monitoring of adaptive equipment. **Recommendation 11, March 2007:** Provide augmentative/adaptive communication assessments and the needed devices for individuals with communications issues. **Findings:** The Adaptive Equipment Tracking Log database did not list any individuals with augmentative communication devices. No individualized communication devices were recommended following assessment according to data provided to this monitor. The facility reports that Boardmaker software has been purchased for use with individuals with communication needs. This is a good initial effort, though augmentative communication devices/systems should be individualized. **Recommendation 12, March 2007:** Monitor and track the regular cleaning and sanitizing of adaptive equipment and wheelchairs. **Findings:** A Wheelchair Cleaning and Maintenance procedure was developed but according to facility report is currently not in use as it is being revised due to a change in departmental responsibilities. A Wheelchair Cleaning Tracking Log was developed but has not yet been implemented. **Other findings:** Audit data reported from MSH audits for March-July 2007 indicates that 54% of Integrated Rehabilitation Therapy Assessments were completed within specified time frames (5 days for initial evaluations and seven days for transfers) according to procedure. Upon record review of assessments done from May-July 2007, it was noted that 100% contained an Integrated Rehabilitation Therapy

		Assessment, 100% of assessments were completed within appropriate time frames, 65% were complete, with all sections addressed, and 81% had findings that were accurate, and consistent with those of other disciplines. According to facility report, 12 Physical Nutritional Physical Support Comprehensive Assessments have been completed. However, according to data table provided, only 8% of these assessments were complete with all sections from all disciplines documented per procedure. Review of four comprehensive Team Assessments for Physical and Nutritional Management indicated that 75% had complete Physical, Occupational, and Speech Therapy sections, with all objective findings sections documented, 0% were found in the medical record, and 0% adequately addressed functional status. Comprehensive assessments did not consistently contain documentation of rationale/justification for clinical recommendations, and 75% of assessments generated Dining Plans which did not seem necessary based on assessment findings. According to facility report, 29 Physical Therapy assessments were completed from March-August 2007. Record review of Physical Therapy Assessments revealed that 82% of Physical Therapy assessments were complete (with refusals excluded), and 9% contained functional and measurable objectives and findings. Review of Speech Therapy Assessments showed that 100% were complete, and 0% contained functional, individualized, and measurable objectives and findings. Review of Occupational Therapy Assessments showed that 100% were complete, and 20% contained functional, individualized, and measurable objectives and findings. Upon record review of Vocational Assessments, it was noted that 88%

		contained complete Work Training Assessments. No WRPT referrals were provided to this monitor. Of the sample of assessments reviewed, 25% were done in response to WRPT request, and 75% were done in response to individual request. Current procedure states that PT, OT, and ST referrals are to be answered within 24 hours, with assessments completed within 48 hours. Review of Qualitative Rehabilitation Audit for July revealed that 67% of Occupational Therapy assessments were completed, and Occupational Therapy referrals and responses were completed in an average of three days from the date of referral to the date of response, and six days from the date of referral to the completion of the assessment. Review of Qualitative Rehabilitation Audit for July revealed that 69% of Physical Therapy assessments were completed, and Physical Therapy referrals and responses were completed in an average of three days from the date of referral to the date of response, and nine days from the date of referral to the completion of the assessment. Review of Qualitative Rehabilitation Audit for July and August revealed that 65% of Speech Therapy Assessments were completed, and Speech Therapy referrals and responses were completed in an average of four days from the date of referral to the date of response, and six days from the date of referral to the completion of the assessment. The current Comprehensive Team Assessment for Physical and Nutritional and Physical Support is focused more on risk and disability/dysfunction than on determination of functional level and abilities and needs/supports. **Current recommendations**: 1. Develop and implement monitoring tool(s) for Physical, Occupational, and Speech Therapy assessments, Vocational Rehabilitation Assessment, and Comprehensive Integrated Physical Rehabilitation

		Assessment to ensure that all assessments are timely and provide a thorough assessment of functional ability as opposed to a focus on dysfunction and disability. 2. Ensure that all individual objectives are functional, meaningful, and measurable. 3. Establish inter-rater reliability for all audit/monitoring tools prior to implementation.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Findings:** According to MSH audit data for March-July 2007, 71% of assessments addressed all physical functioning areas, 75% identified all social functioning areas, 73% identified all cognitive functioning areas, and 38% identified skills and supports needed to transfer to the next level of care. Review of Physical Therapy, Occupational Therapy, Speech Therapy, and Comprehensive Team assessments for Physical Nutritional Management revealed that 0% of Physical Therapy assessments, 0% Speech Language assessments, and 0% of Comprehensive Team assessments had comprehensive documentation of individual's current functional status and supports needed to facilitate transfer to the next level of care. **Current recommendation**: Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Findings:** According to MSH audit data for March-June 2007, 75% of assessments identified the individual's life goals, 74% addressed self report, observations, or collateral sources the individual could use to overcome barriers, and 73% identified motivation for engaging in

		wellness activities. Review of Physical Therapy, Occupational Therapy, Speech Therapy, and Comprehensive Team assessments for Physical Nutritional Management revealed that 20% of Physical Therapy assessments, 0% of Occupational Therapy assessments, 0% Speech Language assessments, and 0% of Comprehensive Team assessments had documentation of identified individual's life goals. **Current recommendation**: Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible. **Findings:** Copies of newly hired Occupational, Physical, and Speech Therapists' licenses and staffing agency competency validation checklists were provided, but no evidence of competency-based training related to MSH policies and procedures including the WRP process and Enhancement Plan requirements were provided to this monitor. **Recommendation 2, March 2007:** Develop and implement a monitoring system to adequately address this requirement. **Findings:** No data was provided to this monitor regarding this requirement.

		Other findings: The Rehabilitation Therapy Manual contains a procedure for New Employee training, and lists the following categories of training for Rehabilitation Therapy staff: Direct Services (documentation, Psychosocial Rehabilitation Mall, and Wellness and Recovery Planning); Indirect Services (e.g., purchasing, requests, and computer usage); Observations; Unit Assignment; and Meeting with Chief of Rehabilitation Services. A Program Orientation is also completed within the new or transferring employee's first week, and includes training in the following areas: Employee Matters; Program Orientation (introductions and roles); Manuals and Policies; and Emergency Procedures. Training regarding Integrated Rehabilitation Therapy Assessments and audits is not currently competency-based, and no training/instructions exist for Comprehensive Team Assessments for Nutritional Physical Management, PT, OT, SLP, or Vocational Therapy Assessments. No evidence of new employee training materials/compliance regarding Rehabilitation Therapy Assessments was provided to this monitor. **Compliance:** Partial. **Current recommendation**: Provide competency-based training to all Rehabilitation Services staff regarding changes in departmental procedures, and to appropriate staff regarding developed/revised assessment protocols and instructions on a discipline/team specific basis.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State	**Current findings on previous recommendation:**

	hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Recommendation, March 2007:** Evaluate the utility of the new Integrated Rehabilitation Therapy Assessment before implementing this requirement. **Findings:** The assessment tool has been revised but requires further revisions in protocol, pilot, and training prior to implementation. **Other findings:** According to facility report, from the March 1, 2007 census of 663, 264 Integrated Rehabilitation Therapy Assessments have been completed and 399 are pending. **Compliance:** Partial. **Current recommendations:** 1. Revise, pilot, and implement revised Integrated Rehabilitation Therapy Assessment. 2. Ensure that all individuals admitted to MSH prior to March 1, 2007 receive an Integrated Rehabilitation Therapy Assessment within the next six months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Mary Christina Marshall, Director of Dietetics 2. Ninfa Guzman, Hospital Administration Resident 3. Portia Salvacion, Assistant Director of Dietetics Reviewed: 1. MSH Policy 4101 General Standards of Nutrition Care 2. MSH Policy 4107 for Clinical Nutrition Charting 3. Nutritional Care Monitoring data for type A assessments from March-July 2007 4. List of individuals who had Nutrition Care type A assessments from March-July 2007 5. Records for the following individuals receiving type A assessments from March-July 2007: NC, DK 6. Nutritional Care Monitoring data for type C assessments from March-July 2007 7. List of individuals who had Nutrition Care type C assessments from March-July 2007 8. Record for the following individual receiving type C assessments from March-July 2007: LS 9. Nutritional Care Monitoring data for type D assessments from March-July 2007 10. List of individuals who had Nutrition Care type D assessments from March-July 2007 11. Records for the following individuals receiving type D assessments from March-July 2007: CP, JK, JM, PQ, CL, NP 12. Nutritional Care Monitoring data for type E assessments from March-July 2007 13. List of individuals who had Nutrition Care type E assessments from March-July 2007

		14. Records for the following individuals receiving type E assessments from March-July 2007: HL, CB, MC, TS 15. Nutritional Care Monitoring data for type G assessments from March-July 2007 16. List of individuals who had Nutrition Care type G assessments from March-July 2007 17. Records for the following individuals receiving type G assessments from March-July 2007: AR, EC, SG, NH, SC 18. Nutritional Care Monitoring data for type I assessments from March-July 2007 19. List of individuals who had Nutrition Care type I assessments from March-July 2007 20. Records for the following individuals receiving type I assessments from March-July 2007: JD, SR, VF, JM, GK, CG 21. Nutritional Care Monitoring data for type J.i. assessments from March-July 2007 22. List of individuals who had Nutrition Care type J.i. assessments from March-July 2007 23. Records for the following individuals receiving type J.i. assessments from March-July 2007: AC, GR, MP, HT 24. Nutritional Care Monitoring data for type J.ii. assessments from March-July 2007 25. List of individuals who had Nutrition Care type J.ii. assessments from March-July 2007 26. Records for the following individuals receiving type J.ii. assessments from March-July 2007: SM, JV, CL, CG, SW
D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Provide compliance rates in alignment with the requirements of the EP.

		Findings: The Nutrition Care Monitoring tool data is collected in a line item format to allow for optimum analysis of data and trends. **Recommendation 2, March 2007:** Continue to monitor this requirement **Findings:** According to facility report, six individuals had type A assessments between April-June 2007. Record review of individuals receiving type A assessments from April-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 75% had complete objective findings, 100% had correctly formulated nutrition diagnoses, 75% had individualized and measurable goals, and 75% had appropriate recommendations. According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete subjective findings, 97% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within three days of	Not applicable—MSH does not have a medical/surgical unit.

	admission.	
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** According to facility report, five individuals had type C assessments between April-June 2007. Only one type C nutrition assessment was made available to this monitor. This assessment was completed on time, had complete subjective and objective findings, correctly formulated Nutrition diagnosis, partial (50%) measurable and individualized objectives, and appropriate recommendations based on assessment findings. According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement.

	surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	**Findings:** According to facility report, 31 individuals had type D assessments between April-June 2007. Record review of individuals receiving type D assessments from April-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 92% had individualized and measurable goals, and 100% had appropriate recommendations. According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** According to facility report, 18 individuals had type E assessments between April-June 2007.

		Record review of individuals receiving type E assessments from April-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 63% had individualized and measurable goals, and 100% had appropriate recommendations. According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete subjective findings, 99% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within seven days of the therapeutic diet order but no later than 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** Individuals who meet the criteria for D.5.f. also meet the criteria for D.5.j.i, and are reviewed/monitored as part of the sample for D.5.j.i. **Other findings:** According to facility report, it is the practice at MSH that, for all newly admitted individuals, a comprehensive Admission Nutrition assessment is completed on or before the fifth day of admission. For those individuals with therapeutic diet orders after completion of

		admission nutrition assessment on or before the fifth day of admission, a reassessment is completed (within seven days of Diet Order Change to Therapeutic diet) via the Diet order Confirmation process. This process ensures the proper integration of data regarding changes that may have occurred after the fifth day of admission. Thus, the monthly which(March through July 2007) monitoring of medical record review/reassessments (Diet Order Change to Therapeutic Diet) was completed, but has been incorporated into F.4.j.i., which looks at re-assessments. **Compliance:** See findings for D.5.j.ii. **Current recommendation**: Continue current practice.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** According to facility report, 62 individuals had type G assessments between April-June 2007. Record review of individuals receiving type G assessments from April-June 2007 indicated that 100% of assessments were completed on time, 80% had complete subjective findings, 90% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 70% had individualized and measurable goals, and 80% had appropriate recommendations.

		According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete subjective findings, 94% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation:** Continue current practice.
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** Record review of all Nutrition Assessments (types A, C, D, E, G, I, J.i, J.ii) revealed that 97% of assessments included a determination of Nutritional Status Type based on assessment findings. According to Nutrition Assessment Monitoring data from March-July 2007, 100% of assessments (types a, c, d, e, g, I, j.i, j.ii) included a determination of Nutritional Status Type based on assessment findings. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor the elements of this requirement. **Findings:** According to facility report, 123 individuals had type I assessments between April-June 2007. Record review of individuals receiving type I assessments from April-June 2007 indicated that 100% of assessments were completed on time, 67% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 80% had individualized and measurable goals, and 100% had appropriate recommendations. According to Nutrition Assessment audit data for March-July 2007, 95% of assessments were completed on time, 100% had complete subjective findings, 93% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Clarify data regarding the timeliness of reassessments.

		Findings: According to facility report, there are three different types of Nutrition Care reassessments. Reassessment when significant changes in condition per consult/high-risk referral are done within 24 hours, seven days, 14 days or as specified by referral timeframe. Reassessments upon non-administrative transfer to medical/surgical unit are done within three days, and transfer to Skilled Nursing Facility are done within seven days. Reassessment upon receipt of Diet Order change to therapeutic diet after completion of the admission assessment on the fifth day of admission is completed within seven days of receipt of diet order change. To evidence compliance with this requirement, the completed Nutritional Care Monitoring Tool form for each type of referral report reviewed indicates the date the referral was ordered and the date the report was completed by the RD. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** According to facility report, 28 individuals had type J.i assessments between April-June 2007. Record review of individuals receiving type J.i assessments from April-June 2007 indicated that 100% of assessments were completed on time, 50% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 50% had individualized and measurable goals, and 100% had appropriate recommendations. According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete

		subjective findings, 98% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** According to facility report, 44 individuals had type J.ii assessments between April-June 2007. Record review of individuals receiving type J.ii assessments from April-June 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 90% had individualized and measurable goals, and 100% had appropriate recommendations. According to Nutrition Assessment audit data for March-July 2007, 100% of assessments were completed on time, 100% had complete subjective findings, 99% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.

		Compliance: Substantial. **Current recommendation**: Continue current practice.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Fatimah Busran, MSW, Social Worker 2. Lee Breitenbach, CSW, Social Worker 3. James Park, CSW, Social Worker 4. Shirin Karimi, LCSW, Chief of Social Work 5. Sonya Rock, ACSW, Social Worker Reviewed: 1. Charts of seven individuals: CH, CX, EA, RU, EM, MJ, and WB 2. DMH 30-Day Psychosocial Assessment 3. DMH 30-Day Psychosocial Assessment Instructions 4. DMH Social History Assessments Audit Form 5. DMH Integrated Social Work Assessment 6. MSH Social Work Monitoring Tools
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Implement the 30-day social history reviews. **Findings:** MSH's Chief of Social Work met with Chiefs from other State facilities on June 13-14, 2007, to finalize the assessments tool and instructions on the 30-day Social History Assessment. The edits/changes to the assessment were approved by DMH Executive Directors Council and the ED at MSH, and the Assessment is ready for implementation. This monitor reviewed the 30-day Social Work Assessment. The assessment is aligned with EP requirements.

		Recommendation 2, March 2007: Include quality indicators in the Social Work monitoring instruments. **Findings:** MSH has included in item #11 (*The assessment contributes to clinical decision-making, discharge planning and aftercare services*) in the DMH Social History Assessments Audit Form as a quality indicator. Shirin Karimi, the Chief of Social Work, indicated that staff needs to be trained in using the newly added quality indicator item. **Recommendation 3, March 2007:** Develop, finalize and implement statewide annual social history evaluations. **Findings:** MSH's Chief of Social Work and other State facility Chiefs of Social Work met on June 13-14, 2007 to finalize the Annual Social History Evaluations. The finalized monitoring form and its instructions were then submitted to the DMH Executive Directors Council for approval. **Recommendation 4, March 2007:** Align monitoring tools with the EP. **Findings:** According to the Chief of Social Work, the Chiefs of Social Work from other State facilities are still working on aligning the monitoring tools with the EP. MSH is also incorporating the feedback given by their CRIPA consultant and the court monitors. **Compliance:** Partial.

<table>
<tr>
<td></td>
<td></td>
<td>Current recommendations:
1. Implement the 30-day social history reviews.
2. Develop, finalize and implement statewide annual social history evaluations.
3. Align monitoring tools with the EP.</td>
</tr>
<tr>
<td>D.6.b</td>
<td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td>
<td>Current findings on previous recommendations:

Recommendation 1-2, March 2007:
1. Ensure that social workers identify and address the inconsistencies in current assessments.
2. Monitor factual inconsistencies in social histories.

Findings:
MSH used item #14 from the 30- Day Assessment Monitoring Form to address this recommendation, reporting 94% compliance. The table below shows the number of new admissions for each month from April to July 2007 (N), the number of assessments audited (n), and the compliance obtained (%C) is a summary of the facility's data.

Resolution of factual inconsistencies

<table>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n</td><td>10</td><td>13</td><td>9</td><td>6</td><td></td></tr>
<tr><td>%S</td><td>24</td><td>36</td><td>28</td><td>13</td><td></td></tr>
<tr><td>%C- 14</td><td>90</td><td>85</td><td>100</td><td>100</td><td>94</td></tr>
</table>

Data for this audit came from a non-random sampling of assessments submitted by the level of care staff submitted to the Chief of Social Work. The data from this sample may result in a higher percentage of compliance than data derived from a random selection of assessments.</td>
</tr>
</table>

The Chief of Social Work used this method due to staffing shortage, as the two Social Workers who were monitors left their positions.

MSH also used item #15 from the 30-Day Assessment Monitoring Form to address this recommendation, reporting 63% compliance. The table below with its monitoring indicator showing the number of new admissions per month (N), the sample reviewed (n), and the percentage of inconsistencies that were resolved or further actions to be taken if the inconsistencies could not be resolved (%C) is a summary of the facility's data.

If inconsistencies exist, did CSW resolve inconsistencies?

	Apr	May	Jun	Jul	Mean
N	41	36	32	45	
N	10	13	9	6	
%S	24	36	28	13	
%C- #15	60	50	75	67	63

As the data in the table above shows, Social Workers on average resolved or indicated further steps to resolving inconsistencies 63% of the time.

This monitor reviewed seven charts (CH, CX, EA, RU, EM, MJ, and WB). Five of them (CX, EA, RU, EM, and WB) addressed matters relating to inconsistencies (for example, CX) or identified and resolved the inconsistencies (for example, RU); one of them (MJ) did not address factual inconsistencies, and one (CH) did not have a 30-day assessment in the chart.

Compliance:
Partial.

<table>
<tr>
<td></td>
<td></td>
<td>Current recommendations:
1. Ensure that social workers identify and address the inconsistencies in current assessments.
2. Monitor factual inconsistencies in social histories.</td>
</tr>
<tr>
<td>D.6.c</td>
<td>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC.

Findings:
MSH used item #59 from the MSH Integrated Assessment Social Work Monitoring Tool to address this recommendation, reporting 90% compliance. The table below showing the number of new admissions per month (N), the number of Integrated Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Document was completed within 5 days of individual's admission date.

<table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>n</td><td>5</td><td>18</td><td>8</td><td>11</td><td></td></tr>
<tr><td>%S</td><td>8</td><td>50</td><td>25</td><td>25</td><td></td></tr>
<tr><td>%C- #59</td><td>100</td><td>94</td><td>75</td><td>91</td><td>90</td></tr>
</table>

This monitor reviewed six charts (CX, EA, RU, EM, MJ, and WB) containing the Integrated Social Work Assessment. In five of them (CX, EA, RU, EM, and MJ) the Integrated Assessments were present and timely, and in one of them (WB) the assessment was not timely.</td>
</tr>
</table>

Recommendation 2, March 2007:
Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the 30th day of admission.

Findings:
MSH used item #1 from the 30-Day Social Work Monitoring Form to address this recommendation, reporting 68% compliance. The table below showing the number of new admissions each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Completed within 30 days

	Apr	May	Jun	Jul	Mean
N	41	36	32	45	
n	10	13	9	6	
%S	24	36	28	13	
%C-# 1	60	62	67	83	68

According to the Chief of Social Work, the Social Work Department had experienced a chronic shortage in the Level of Care Social Work staff, ranging from 24% -39%, from March-August 2007. The staffing shortage placed a large case load on the remaining staff, creating difficulty in completing the assessments on time. The table below showing the staffing vacancy patterns is a summary of the facility's data:

Level of Care staffing in the Social Work Department.

	Mar	Apr	May	Jun	Jul	Aug
Number of allotted positions	33	33	33	33	33	33
Number of	8	13	12	12	12	8

		vacancies | | | | | | | Number of new hires | 1 | 1 | 0 | 0 | 0 | 4 | Percentage of vacancies | 24 | 39 | 36 | 36 | 36 | 24 | This monitor reviewed six charts (RU, EM, MJ, WB, EA, and CX). Three of them (CX, EM, and MJ) had the 30-day social histories completed in a timely manner, and three of them (EA, RU, and WB) were not timely. **Compliance:** Partial. **Current recommendations**: 1. Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the 30th day of admission.
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status. **Findings:** MSH used item #6 from the 30-Day Assessment Monitoring Form to address this recommendation, reporting 100% compliance. The table below shows the number of new admissions per month (N), the number of assessments audited (n), and the compliance rate (%C). *Developmental / family & interpersonal history*

	Apr	May	Jun	Jul	Mean
N	41	36	32	45	
n	10	13	9	6	
%S	24	36	28	13	
%C - #6	100	100	100	100	100

This monitor reviewed six charts (CX, EA, RU, EM, MJ, and WB). All six of them included entries of the individual's educational status and social factors, some in more detail than others. However, in many cases the sources for the information was not clearly stated.

Compliance:
Substantial.

Current recommendations:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

7. Court Assessments		
		Methodology: Interviewed: 1. Michael Barsom, MD, Acting Medical Director. 2. David Niz, MD, Chief of Forensic Psychiatry. Reviewed: 1. Charts of seven individuals admitted under PC 1026 (BR, AL, BDM, OCG, LH, BRB and HS). 2. Charts of six individuals admitted under PC 1370 (TWJ, TW, TF, CX, AZ and RGT). 3. DMH Manual for the Preparation of PC 1026 and PC 1370 Court Reports. 4. Court Reports Monitoring Form PC 1026. 5. Court Reports Monitoring PC 1026 summary data (March to July 2007). 6. Court Reports Monitoring Form PC 1370. 7. Court Reports Monitoring PC 1370 summary data (March to July 2007). 8. AD #0206, Forensic Review Panel (FRP) effective June 19, 2007. 9. Sample of e-mail feedback from FRP to WRPTs for individuals PM, UJ, AL, SA, BT, JJ and AZ. 10. Minutes of FRP meetings since March 2007.
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports	**Compliance:** Partial.

	should include the following, as clinically indicated:	
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to monitor this requirement. **Findings:** MSH used the Court Reports Monitoring Form PC 1026 to assess compliance with D.7.a.i through D.7.a.ix. All 1026 court submissions were reviewed during the period March to July 2007. The mean compliance rate reported for this item was 93%. **Recommendation 2, March 2007:** Address and correct factors related to low compliance. **Findings:** MSH's data indicate improved compliance with this requirement. Although chart reviews by this monitor (D.1.a.i through D.7.a.ix) showed some improvement during this review period, the monitor's findings generally revealed compliance rates that were significantly lower than those reported by the facility. **Other findings:** This monitor reviewed the charts of seven individuals admitted under PC 1026 (BR, AL, BDM, OCG, LH, BRB and HS). Dr. Barsom, Acting Medical Director and Dr. Niz, newly appointed Chief of Forensic Psychiatry, participated in this review. The monitor found compliance in three charts (BDM, BRB and HS), non-compliance in three (BR, AL and LH) and partial compliance in one (OCG). **Current recommendations**: 1. Continue to monitor this requirement. 2. Address and correct factors related to low compliance.

D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** MSH reported a mean compliance rate of 82%. **Other findings:** This monitor's reviews revealed compliance in four charts (BR, BDM, OCG and LH) and partial compliance in three (AL, BRB and HS). **Current recommendations**: Same as above.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** MSH reported a mean compliance rate of 77%. **Other findings:** This monitor found non-compliance in three charts (BR, AL and LH), compliance in two (BDM and HS) and partial compliance in one (OCG). **Current recommendations**: Same as above.
D.7.a.iv	acceptance of mental illness and understanding of the need	**Current findings on previous recommendation:**

	for treatment, both psychosocial and biological, and the need to adhere to treatment;	**Recommendation, March 2007:** Same as above. **Findings:** The facility reported a mean compliance rate of 94%. **Other findings:** This monitor found partial compliance in three charts (BDM, LH and HS), compliance in two (OCG and BRB) and non-compliance in two (BR and AL). **Current recommendations**: Same as above.
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** The facility' reported a mean compliance rate of 90%. **Other findings:** This monitor found compliance in five charts (BR, AL, BDM, OCG and BRB), partial compliance in one (HS) and non-compliance in one (LH). **Current recommendations**: Same as above.
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above.

		Findings: MSH reported a mean compliance rate of 81%. **Other findings:** This monitor found partial compliance in four charts (OCG, LH, BRB and HS), compliance in one (BDM) and non-compliance in one (BR). This requirement was not applicable to the chart of AL. **Current recommendations**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** The facility reported a mean compliance rate of 60%. **Other findings:** This monitor found compliance in three charts (BDM, OCG and HS) and partial compliance in one (AL). This requirement did not apply to the charts of BR, LH and BRB. **Current recommendations**: Same as above.
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above.

		Findings: The facility reported a mean compliance rate of 66%. **Other findings:** Reviews by this monitor showed non-compliance in four charts (AL, BDM, OCG and LH) and partial compliance in three (BR, BRB and HS). **Current recommendations**: Same as above.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** MSH reported a mean compliance rate of 44%. **Other findings:** This monitor found non-compliance in all charts (BR, AL and BRB) where this requirement was applicable. **Current recommendations**: Same as above.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy	**Compliance:** Partial.

	trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** Using the Court Reports Monitoring Form, MSH reviewed 100% of court submissions during the period March to July 2007 to assess compliance with D.7.b.i through D.7.b.iv. The facility reported a mean compliance rate of 99% with this requirement. **Other findings:** This monitor reviewed charts of six individuals admitted under PC 1370 (TWJ, TW, TF, CX, AZ and RGT). Dr. Barsom, Acting Medical Director and Dr. Niz, the newly appointed Chief of Forensic Psychiatry, participated in this review. The monitor's findings showed some improvement during this review period, but the rates of compliance were generally lower than those reported by the facility. Regarding this requirement, the monitor found partial compliance in three charts (TW, AZ and RGT), compliance in two (TWJ and TF) and non-compliance in one (CX). **Current recommendations**: Same as D.7.a.i (as applicable to PC 1370).

D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** MSH reported a mean compliance rate of 96%. **Other findings:** This monitor found compliance in four charts (TWJ, TW, TF and CX) and partial compliance in two (AZ and RGT). **Current recommendations**: Same as above.
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** The facility reported a mean compliance rate of 98%. **Other findings:** This monitor found compliance in three charts (TWJ, AZ and RGT), partial compliance in two (TW and TF) and non-compliance in one (CX). **Current recommendations**: Same as above.
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after	**Current findings on previous recommendation:**

	discharge.	**Recommendation, March 2007:** Same as above. **Findings:** The facility reported a mean compliance rate of 75%. **Other findings:** This monitor found partial compliance in two charts (TWJ and TF) and compliance in one (TW). This requirement was not applicable in the charts of CX, AZ and RGT. **Current recommendations**: Same as above.
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction	**Current findings on previous recommendation:** **Recommendation, March 2007:** Develop and implement a procedure that specifies the duties and responsibilities of the FRP. **Findings:** MSH has addressed this recommendation. AD 0206 outlines the facility's expectations regarding the functioning of the FRP. However, the AD does not clearly specify that the FRP will review the WRPTs' response to its feedback and ensure that all court reports are modified as appropriate prior to submission to the courts. **Compliance:** Partial. **Current recommendations**: Revise AD 0206 to include that the FRP shall review the responses by the WRPTs to its feedback and ensure that all court reports are

		modified as appropriate prior to submission to the courts.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that minutes of the FRP meetings adequately document activities of the panel. **Findings:** MSH has yet to implement this recommendation. The FRP is being reconstituted and the format for conducting the panel meetings has been changed to address this recommendation. **Compliance:** Partial. **Current recommendations**: Ensure that minutes of the FRP meetings adequately document activities of the panel.

E. Discharge Planning and Community Integration		
		Summary of Progress: 1. The Chief of Social Work has a much better understanding of the department's role in supporting MSH to achieve compliance with EP. 2. The Social Work Department has developed, and in many cases implemented, the necessary auditing/monitoring tools, and in some cases is awaiting approval of the newly developed tools from DMH and/or MSH. 3. MSH has improved its coordination/communication with CONREP and other community agencies to address discharge issues. 4. MSH's 7-Day and 30-Day Assessments have improved in timeliness and comprehensiveness.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. Ten individuals: LP, NV, AH, AB, LR, AB, RRC, JY, QV, and FG) 2. Fatimah Busran, MSW, Social Worker 3. Lee Breitenbach, CSW, Social Worker 4. James Park, CSW, Social Worker 5. Shirin Karimi, LCSW, Chief of Social Work 6. Sonya Rock, ACSW, Social Worker <u>Reviewed</u>: 1. Charts of 51 individuals: AG, AH. BB, CD, CG, CJ, CK, CM, DM, DW, DY, E J, ELM, FR, GD, GF, IG, IRC, JD, JE, JK, JM, JMA, JME, , JP, JS, KH, KM, KO, LA, LJ, LR, LS, MB, MC, MCF, ME, MF, MJ, NH, NM, PW , RAV, RB, RD, RR, SB, SFY, SG, TP, and TS 2. MSH August, 2007, Progress Report 3. MSH WRP Observation Monitoring Form 4. DMH WRP Discharge Planning and Community Integration Audit Form

		5. Social Work Assessment Monitoring form Instruction Sheet 6. Social Feedback Monitoring Form 7. MSH 30-Day Social Work Assessment Monitoring Form 8. DMH Case Formulation Monitoring Form 9. DMH Case Formulation Monitoring Instruction Form 10. DMH WRP Discharge Planning and Community Integration Audit Form 11. List of Individuals in Level of Care Considerations 12. MSH Mall Catalogue 13. List of Individuals Residing for 180 Days or Longer 14. MSH Performance Improvement Checklist, for Individuals Residing Longer than 180 Days <u>Observed</u>: 1. Five WRP Conferences: RJ, Unit 407, Program 5; JP, Unit 419, Program 6; JB, Unit 415, Program 111; MA, Unit 415, Program 3; and CD, Unit 407, Program 5 2. Five PSR Mall Groups: Stay Tuned, Bed-Bound Unit 418 and 419; Drug Education Program, Substance Recovery, Unit 409, Program 3; Communication Through Music, Unit 420, Program 6; Bridge to Recovery, Unit 409, Program 3; and Conflict Resolution, Unit 405, Program 5
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that discharge setting and relevant skills for that setting are developed at the first seven-day WRP. **Findings:** MSH used items #10 and #12 from the MSH WRP Observation Monitoring Form to address this recommendation, reporting 27% and 42% respectively. The table below with its monitoring indicators

showing the number of WRPCs for the months from March to July, 2007 (N), the number of WRPCs observed (n), and the percentage of compliance observed (%C) is a summary of the facility's data.

#10: *The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the needs of the individuals assessed needs, consistent with his/her legal status.*

#12: *Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.*

	Mar	Apr	May	Jun	Jul	Mean
N	38	41	36	32	45	
n	3	1	2	2	0	
%S	9	2	8	9	0	
%C-# 10.	33	0	50	50	0	27
n	4	1	3	3	0	
%S	9	2	8	9	0	
%C -#12	75	0	67	67	0	42

As the data shows, matters relating to discharge settings and skills the individual needs to adapt to the discharge setting are not regularly addressed during the WRPC. It is imperative that the individual's next discharge setting be identified as early as possible so that the skills and support the individual needs for successful transition is addressed through PSR services.

This monitor reviewed 11 WRPs (ME, MC, DM, MF, MB, JE, CK, AH, RD, RAV, and JP). Three of them (DM, MF, and CK) had some discussion on

matters related to the individual's discharge, and the other eight (ME, MC, MB, JE, AH, RD, RAV, and JP) did not address the issue.

Recommendation 2, March 2007:
Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria.

Findings:
MSH used item #10 from the MSH WRP Observation Monitoring Form to address this recommendation, reporting 38% compliance. The table below with this monitoring indicator showing the number of WRPCs for the months from march to July 2007 (N), the number of WRPs audited by chart review (n), and the compliance obtained (%C) is a summary of the facility's data.

The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the needs of the individuals assessed needs, consistent with his/her legal status.

	Mar	Apr	May	Jun	Jul	Mean
N	653	674	810	683	659	
N	35	24	41	66	51	
%S	5	4	5	10	8	
%C- 10	40	38	42	36	35	38

This monitor reviewed nine charts (ME, MC, JS, CG, LR, MJ, CD, LJ, and RB). Four of them (ME, JS, CG, and LR) have properly developed discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy showing linkage amongst them, and five of them (MC, MJ, CD, LJ, and RB) had one or more incorrect/missing elements.

Recommendation 3-5, March 2007:

3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC.
4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.
5. Develop a tool to monitor these requirements.

Findings:

MSH used item #10 from the WRP Observation Monitoring Form to address this recommendation, reporting 38% compliance. The table below with its monitoring indicator showing the number of WRP Conference per month (N), the number of WRPs audited by chart review (n), and the compliance obtained (%C) is a summary of the facility's data.

The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the needs of the individuals assessed needs, consistent with his/her legal status.

	Mar	Apr	May	Jun	Jul	Mean
N	653	674	810	683	659	
n	35	24	41	66	51	
%S	5	4	5	10	8	
%C -10.	40	38	42	36	35	38

According to the Chief of Social Work, Social Work staff has been trained to specifically discuss item items #10 and #12 at WRPCs. Furthermore, WRP Observation Forms are now included as part of the feedback process to Social Work staff.

This monitor reviewed six charts (MC, RB, JM, DW, KO, and MJ). A

		review of the WRPs showed that three of them (RB, JM, and KO) had documented evidence that the individual's discharge criteria and discharge status were reviewed, and three of them (MC, DW, and MJ) did not have proper documentation. None of the WRPs showed any evidence that the discharge related matters were discussed with the individuals'. MSH used item #10 to address recommendations in this cell. However, item #10 is not specific to elements required for each of the recommendations in this cell. Thus, the percentage of compliance obtained may be low. The Chief of Social Work had recognized the non-specificity of item #10 to address the recommendations and has developed additional instructions for the DMH WRP Discharge Planning and Community Integration Audit Form, and is awaiting approval from DMH. **Other findings:** WRPTs need further training in pathway to services. In a number of cases (for example, 7-Day WRPC on CM, JP, and AH), statements similar to "No PBS required at this time" are made on new admits before necessary assessments (for example cognitive screening and focused assessments) and interventions through behavior guidelines are attempted. **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge setting and relevant skills for that setting are developed at the first seven-day WRP. 2. Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria.

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<td>3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC.
4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.
5. Develop a tool to monitor these requirements.</td>
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<tr>
<td>E.1.a</td>
<td>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.

Findings:
MSH used item #7 from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 53% compliance. The table below with its monitoring indicator showing the number of WRPs due for each month (N), the number audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>653</td><td>674</td><td>810</td><td>683</td><td>659</td><td></td></tr>
<tr><td>n</td><td>1</td><td>2</td><td>39</td><td>69</td><td>49</td><td></td></tr>
<tr><td>%S</td><td>5</td><td>4</td><td>5</td><td>10</td><td>7</td><td></td></tr>
<tr><td>%C-# 7</td><td>100</td><td>50</td><td>51</td><td>26</td><td>39</td><td>53</td></tr>
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MSH also used item #12 from the 30-Day Social Work Assessment Monitoring Form to analyze if the 30-Day Social Work Assessment includes strengths/preferences/interests of the individuals, reporting</td>
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98% compliance. The table below with its monitoring indicator showing the number of new admissions for each month (N), the number of Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Strengths / Recovery opportunities

	Apr	May	Jun	Jul	Mean
N	41	36	32	45	
n	10	13	9	6	
%S	24	36	28	13	
%C -12	100	92	100	100	98

As the data in the table above shows, almost all the 30-Day Social Work Assessments include information pertaining to the individual's strength, interest, and preference. However, this information is either not reviewed or not used when developing foci and interventions as a means of achieving the individual's discharge criteria.

This monitor reviewed 19 charts (JP, RD, AH, CK, JS, LI, SG, JE, GF, MC, RB, DW, GD, BB, DY, NH, JMA, JME, and KO). One of them (JE) consistently identified the individual's strengths, interests, and preferences linked to the interventions, and the remaining 18 (JP, RD, AH, CK, JS, LI, SG, GF, MC, RB, DW, GD, BB, DY, NH, JMA, JME, and KO) did not have the individual's strengths, interests, and preferences in each of the interventions in the WRP.

Recommendation 2, March 2007:
The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.

Findings:
MSH did not audit this recommendation.

		This monitor reviewed eight charts (ME, MC, KO, JMA, RB, DW, JM, and IG), One of them (DW) had used the individual's life goals to a foci with associated intervention, and the others (ME, MC, KO, JMA, RB, JM, and IG) did not utilize the individual's life goals as a foci and or/intervention. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP. **Findings:** MSH used item #9 from the WRP Case Formulation Monitoring form to address this recommendation, reporting 18% compliance. The table below with its monitoring indicator showing the number of WRPs for April and May, 2007 (N), the number of WRPs reviewed through chart audit (n), and the compliance obtained (%C) is a summary of the facility's data. *Does the case formulation include a review and analysis of important*

clinical factors across multiple domains (Medical, psychiatric, behavioral, functional status, and quality of life) that may affect the treatment and rehabilitation outcomes?

	Apr	May	Mean
N	523	583	
N	10	4	
%S	2	1	
%C- 9.	10	25	18

MSH also used item #5 from the Clinical Chart Audit Form, reporting 24% compliance. The table below with its monitoring indicator showing the number of WRPs for June and July, 2007 (N), the number of WRPs reviewed through chart audit (n), and the compliance obtained (%C) is a summary of the facility's data.

The case formulation considers biomedical, psychosocial, and psycho educational factors, as clinically appropriate, for each of the 6Ps: pertinent History; predisposing and perpetuating factors; previous treatment history, and present status."

	Jun	Jul	Mean
N	521	465	
n	4	31	
%S	0	7	
%C -5	0	48	24

This monitor reviewed eight charts (ME, MC, KO, RB, DW, GD, JM, and JMA). Five of them (ME, MC, RB, DW, and JMA) included the level of psychosocial functioning (functional status) in the individual's Present Status section of the WRP, and three of them (GD, KO and JM) did not include, or lacked clarity when addressed. For example, GD's functional status is stated as, "ADLs: Fair".

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<td>Compliance:
Partial.

Current recommendations:
Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.</td>
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<td>E.1.c</td>
<td>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.

Findings:
MSH used item #10 from the WRP Observation Monitoring Form to address this recommendation, reporting 38% compliance. The table below with its monitoring indicator showing the number of WRPs due for each month (N), the number of WRPs audited through chart reviews (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the needs of the individual's assessed needs consistent with his/her legal status.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>653</td><td>674</td><td>810</td><td>683</td><td>659</td><td></td></tr>
<tr><td>n</td><td>35</td><td>24</td><td>41</td><td>66</td><td>51</td><td></td></tr>
<tr><td>%S</td><td>5</td><td>4</td><td>5</td><td>10</td><td>8</td><td></td></tr>
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%C -10	40	38	42	36	35	38

This monitor reviewed five charts (ME, MC, JK, JD, and CJ). One of them (MC) had documentation indicating that a discussion of discharge progress/barriers was held with the individual, and four of them (ME, JK, JD, and JC) did not have any indication of such a discussion with the individual. In some cases, a Social Work note included information regarding the individual's discharge barriers (RB), and this information was not included in the discussion with the individual or entered into the Present Status section of the WRP. In other cases, information found in other sections of the case formulation (for example, in the Precipitation section of KO's WRP) was not used for discussion with the individual.

Recommendation 2, March 2007:
Include all skills training and supports in the WRP so that the individual can overcome the stated barriers.

Findings:
MSH did not audit this recommendation. According to the Chief of Social Work, the "Discharge Monitoring Tool" has been submitted to DMH on June 20, 2007 for approval.

This monitor reviewed six charts (MC, ME, JK, RP, JD, and CJ). Three of them (RP, JK, and CJ) included skills training and/or supports needed for the individual to overcome discharge barriers, and three of them (MC, ME, and JD) did not provide such information.

Recommendation 3, March 2007:
Report to the WRP team, on a monthly basis, the individual's progress in overcoming the barriers to discharge.

Findings:
MSH used item #10 from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 37% compliance. The table showing the number of WRPs due monthly (N), the number of WRPs audited through chart review (n), and the compliance obtained (%C) is a summary of the facility's data.

The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the needs of the individuals assessed needs, consistent with his/her legal status.

	Mar	Apr	May	Jun	Jul	Mean
N	566	520	581	598	533	
n	29	20	34	60	51	
%S	5	4	6	14	10	
%C-#10	38	40	38	33	35	37

This monitor reviewed nine charts (JE, BB, KM, SG, JP, AG, SB, MC, and ME). Four of them (AG, JP, BB, and JE) had documentation of discussion of progress towards overcoming discharge barriers, and five of them (SG, KM, SB, MC, and ME) did not include such information.

Compliance:
Partial.

Current recommendations:
1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.
2. Include all skills training and supports in the WRP so that the individual can overcome the stated barriers.
3. Report to the WRPT, on a monthly basis, the individual's progress in

<table>
<tr><td></td><td></td><td>overcoming the barriers to discharge.</td></tr>
<tr><td>E.1.d</td><td>the skills and supports necessary to live in the setting in which the individual will be placed.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Assess skills and supports deficits the individual may have for the intended placement.

Findings:
MSH used item #12 from the 30-Day Assessment Monitoring Form to address this recommendation, reporting 98% compliance. The table below with its monitoring indicator showing the number of new admissions for the month (N), the number of 30-Day Assessments audited through chart reviews (n), and the percentage compliance obtained (%C) is a summary of the facility's data.

Strengths / Recovery opportunities

<table>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>41</td><td>36</td><td>32</td><td>45</td><td></td></tr>
<tr><td>N</td><td>10</td><td>13</td><td>9</td><td>6</td><td></td></tr>
<tr><td>%S</td><td>24</td><td>36</td><td>28</td><td>13</td><td></td></tr>
<tr><td>%C-12</td><td>100</td><td>92</td><td>100</td><td>100</td><td>98</td></tr>
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This monitor reviewed eight charts (MC, JM, GD, CK, MB, RP, JS, and EJ). Five of the WRPs in the charts (JM, RP, GD, MB, and JS) included information on the skills and/or supports deficits of the individual for the next placement in the Present Status section of the individual's WRP, and included objectives and interventions to address these deficits. Three of them (CK, MC and EJ) did not include sufficient information regarding the individuals' skills/supports deficits and/or develop objectives and interventions to address the deficits. For</td></tr>
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		example, CK (PC, 1370, Incompetent to Stand Trail) has cooperation skills with his attorney, knowledge of courtroom roles, and understanding of consequences of plea option as criteria for discharge. However, there is no indication in the Present Status section of his WRP if his language, concentration, memory, and social/cooperation skills required to achieve his discharge criteria were strengths or deficits. MSH's compliance data for this recommendation is significantly different from the percentage of compliance obtained by this monitor. The difference is due to the different sources of information. MSH data is derived from the 30-day assessment and the monitor's data comes from the Present Status section of the individual's WRP. However, this difference also highlights the often-noted poor integration of information from assessments (Social work and Psychology Assessments) into the WRPC and/or documentation in the Present Status section of the individual's WRP's. **Recommendation 2-3, March 2007:** 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP at the next scheduled conference. **Findings:** MSH used items #5 and #12 from the 30-Day Assessment Monitoring Form to address this recommendation reporting, 98% compliance. The table below with its monitoring indicators showing the number of new admissions audited (N), the number of 30-Day Assessments reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data. #5: *Persons affiliated with the individual identified.*

#12: *Strengths / Recovery opportunities.*

	Apr	May	Jun	Jul	Mean
N	41	36	32	45	
n	10	13	9	13	
%S	24	36	28	29	
%C-5	100	100	100	100	
%C 12	100	92	100	100	98

MSH also used items #5, #6, and #10 from the Integrated Assessment Monitoring Tool to address this recommendation, reporting 98% compliance. The table below with its monitoring indicators showing the number of new admissions audited (N), the number of 30-Day Assessments reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#5: *Individual's prior type of living arrangement is identified (appropriate box is checked off).*

#6: *Duration of individual's prior living arrangement is identified.*

#10: *Upon discharge, Individual may return to pre-hospitalization living situation or will need a new living situation (appropriate box is checked off).*

	Apr	May	Jun	Jul	Mean
N	41	36	32	34	
n	5	18	8	11	
%S	8	50	25	25	
%C#5	80	94	100	100	93.5
%C-#6	60	78	63	82	70.75
%C-#10	100	94	100	100	99

		This monitor's findings are in agreement with MSH's Social Work Integrated Assessment data showing that a high percentage of assessments include the individual's skills and support. This monitor reviewed seven charts (MC, NH, AMA, EL, DR, JRB, and JM), and only two of them (JRB and NH) included the results of the assessment data into the individual's WRP, and the other five (MC, AMA, EL, DR, and JM) did not integrate the information into the WRPs. **Compliance:** Partial. **Current recommendations**: 1. Assess skills and supports deficits the individual may have for the intended placement. 2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 3. Include these skills and supports in the individual's WRP at the next scheduled conference.
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that the individual is an active participant in the discharge planning process. **Findings:** MSH used item #12 from the WRP Observation Monitoring Form to address this recommendation, reporting 63% compliance. The table below with its monitoring indicator showing the number of WRPs for the month (N), the number audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.

	Mar	Apr	May	Jun	Jul	Mean
N	653	674	810	648	659	
n	34	18	38	57	38	
%S	5	3	5	9	6	
%C - 12	53	61	55	65	79	63

According to the Chief of Social Work, Social Work staff has been given feedback as to their role in WRPCs with the emphasis on reporting/recommendations on discharge-related matters.

This monitor reviewed eight WRPs of individuals newly admitted under PC 1370 (JE, SG, LI, JS, JP, RD, AH, and CK). None of them had documentation to show that the individual was an active participant in the discharge planning process. This monitor reviewed an additional seven monthly/quarterly WRPs (MC, RB, JS, JMA, KM, GD, and BB). Three of them (KM, GD, and BB) had documentation to show that the individual was an active participant, and four of them (MC, RB, JS, and JMA) did not.

Recommendation 2, March 2007:
Develop individualized and measurable discharge criteria.

Findings:
MSH did not audit this recommendation. MSH is training Level of Care

		staff on writing individualized and measurable discharge criteria. The instructions for writing measurable discharge goals have been included in the Social Work Manual. This monitor reviewed nine charts (MC, JMA, RB, JS, LS, NH, KH, TS, and MCF). Four of them (JMA, RB, JS, and LS) had developed discharge criteria that were measurable, and five of them (MC, NH, KH, TS, and MCF) had one or more discharge criteria that was not measurable. For example, one of KH's discharge criteria read "Ms. H must be medically stable". A review of KH's diagnosis and Foci showed that KH's medical issues included constipation, respiratory difficulties, and dysphagia. In addition, the beginning sentence in KH's Present Status section stated "K. declined to attend today's conference" but the sentence at the end of the section reads "K. seemed to listen but did not offer any new information. She was asked if she wanted a copy of her WRP and the team agreed that this would be good for her to review." **Recommendation 3, March 2007:** Prioritize objectives and interventions related to the discharge processes. **Findings:** MSH did not audit this recommendation. According to the Chief of Social Work this will be addressed once the Discharge Audit Form is developed and implemented. This monitor reviewed ten charts (MC, JMA, RB, ELM, CK, NM, TP, NH, KH, and JS). Seven of them (MC, JMA, RB, ELM, CK, NM, and TP) and objectives and interventions related to their discharge process, and three of them (NH, KH and JS) did not. For example, KH has discharge criteria for self injurious/suicidal behaviors but there were no corresponding objectives and interventions for the criteria.

		Compliance: Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Develop individualized and measurable discharge criteria. 3. Prioritize objectives and interventions related to the discharge processes.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Current findings on previous recommendation:** **Recommendation, March 2007:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP. **Findings:** MSH used items #10 and #12 from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 38% and 63% compliance respectively. The table below with its monitoring indicators showing the number of WRPCs for the particular month (N), the number of conferences observed (n), and the percentage compliance (%C) obtained are summaries of the facility's data. #10: *The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the needs of the individuals assessed needs, consistent with his/her legal status.* #12: *Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the*

individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.

	Mar	Apr	May	Jun	Jul	Mean
N	653	674	810	683	659	
n	35	24	41	66	51	
%S	5	3	5	10	8	
%C 10.	40	38	42	36	35	38
n	34	18	38	57	38	
%S	5	3	5	9	6	
%C 12.	53	61	55	65	79	63

MSH 's audit of item #10 required the WRPCs to review the Mall progress notes, in addition to discussing the individual's discharge related matters during the WRPC to meet compliance. However, the analysis did not differentiate WRPTs that had Mall progress notes to review but did not, and those who had no Mall progress notes but addressed discharge matters. According to the Chief of Social Work, the auditing staff had reported that the low compliance was due to failure of the WRPTs in reviewing Mall notes, and not because discharge matters were not discussed.

This monitor reviewed 17 charts (MC, JMA, JS, RB, NH, SFY, LA, IG, BB, GD, KM, MF, RR, RAV, PW, DM, and FR). Two of them (JMA and MC) covered most of the process, procedures, and documentation closely following the DMH WRP process for discharge planning, and the remaining sixteen (JS, MC, RB, NK SFY, LA, IG, BB, GD, KM, MF, RR, RAV, PW, DM, and FR) failed to satisfy the criteria in one or more areas. For example, missing dates (MF), non-measurable discharge criteria (BB), no names of providers (KM), life goals were not developed into a foci with relevant interventions (IG), and no signatures of WRPT members and the individual (NH).

		Compliance: Partial. **Current recommendation**: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms. **Findings:** MSH did not audit this recommendation. This monitor reviewed five charts (MC, JMA, JS, RB, and BB). One of them (JMA) had a majority of the interventions in behavioral and measurable terms, and four of them (MC, JS, RB, and BB) did not. **Compliance:** Partial. **Current recommendation**: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms.
E.3.b	the staff responsible for implement the interventions; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that for each intervention in the Mall or for individual therapy,

		the name of the staff member responsible is noted. **Findings:** MSH did not audit this recommendation. This monitor reviewed nine charts (IG, KM, RR, GD, LA, SFY, MC, KM, and NH). None of them included the names of the staff member responsible for the activity in each of the interventions in the individual's WRP. For example, one of KM's intervention reads, "Individual will be encouraged to rest or engage in activities as tolerated," intervention for GD reads, "Mr. D. will go to mental and physical health education groups and in order to learn the signs and symptoms of illness," and one of IG's intervention reads, "Emphasize the importance of early reporting of vision changes." **Recommendation 2, March 2007:** Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. **Findings:** MSH did not audit this recommendation. According to the Chief of Social Work, Mall Coordinators for each program were responsible for updating Mall schedules. The schedules are available to the teams and should be used during WRPCs. This monitor reviewed five charts (JMA, JS, RB, MC, and LK). One of them (JMA) was a match between the staff listed in the WRP, the staff listed on the Mall Schedule, and the staff actually facilitating the activity, group, or intervention, the other four (JS, RB, MC, and LK) did not. For example, there was no identified facilitator for MC. The provider identified for LK in the intervention section of the WRP was not the same as the provider in the PSR Mall services.

		Recommendation 3, March 2007: Ensure that there is a system for identifying when a staff member is no longer responsible for the individual's assigned group and that the WRPT is alerted. **Findings:** MSH is relying on the Mall Coordinators to update Mall schedules to include the name of the primary facilitators. There is no requirement that the information is directly communicated to the WRPTs. It may be helpful for the Mall Coordinators to submit changes directly to the WRPTs. **Compliance:** Partial. **Current recommendations:** 1. Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 3. Ensure that there is a system for identifying when a staff member is no longer responsible for the individual's assigned group and that the WRPT is alerted.
E.3.c	The time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, March 2007:** For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC. **Findings:** MSH used item #8 from the DMH WRP Observation Monitoring Form

<table>
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<td>to address this recommendation, reporting 61% compliance. The table below with its monitoring indicator showing the number of WRPs for the month (N), the number of WRPC observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives.

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>653</td><td>674</td><td>810</td><td>683</td><td>659</td><td></td></tr>
<tr><td>n</td><td>32</td><td>19</td><td>38</td><td>62</td><td>35</td><td></td></tr>
<tr><td>%S</td><td>5</td><td>3</td><td>5</td><td>9</td><td>5</td><td></td></tr>
<tr><td>%C- 8</td><td>47</td><td>58</td><td>58</td><td>66</td><td>74</td><td>61</td></tr>
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This monitor reviewed seven charts (MC, JMA, JS, RB, SG, FR, and IRC). Five of them (JMA, JS, RB, IRC, and SG) had time frames identified for each intervention, and two of them (MC and FR) did not include time frames for each of the interventions in the individual's WRP.

Compliance:
Partial.

Current recommendation:
For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.</td>
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<tr>
<td>E.4</td>
<td>Each State hospital shall provide transition supports and services consistent with generally</td>
<td>Compliance:
Partial.</td>
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	accepted professional standards of care. In particular, each State hospital shall ensure that:	
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. **Findings:** MSH is working with the Forensic Department to develop a tracking system to address this recommendation. MSH is also working with the county ALOC programs to facilitate community placement. The Chief of Social Work is well informed of the internal and external factors that are barriers to timely discharge. Most of the delays stem from external factors. For example, individuals under forensic status who achieve discharge goals are often not released by court to the community because the District Attorney/court is unwilling to release the individual who, in their view, has not served enough time. Lack of beds for individuals on court ordered placements is also an external factor. MSH is addressing many of the system factors through improvement in the court report process, increase in communication with the county ALOC teams, updating WRPTs with monthly progress notes, and creating a court report writing team. This monitor reviewed the list of individuals referred for discharge and are still hospitalized. The list contained a total of 57 individuals. The list did not include the reasons as to why the individuals are still hospitalized. This list did not include the individuals admitted under PC 1370. According to Shirin Karimi, Chief of Social Work, these individuals almost always are discharged within a month after their court competency.

		Recommendation 3, March 2007: Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. **Findings:** MSH does not have a system in place to track/monitor data of individuals delayed from their discharge, especially for the Forensic individuals'. The Chief of Social Work stated that the reasons for delays can be captured through the level of care Social Work staff, and she intends to set up a system to receive the data from the LOC Social Work staff. **Current recommendations**: 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. Ensure and document that individuals receive adequate assistance when they transition to the new setting. 2. Continue with current practices. **Findings:** MSH did not audit this recommendation. According to Shirin Karimi, Chief of Social Work, all Programs include Discharge Planning and or Community Integration groups who are responsible to identify and arrange for the individual's transition support needs.

		This monitor reviewed four charts (MC, JMA, JS, and RB). None of them included any discussion/recommendation on the individual's transition needs or if MSH was able to provide any support to the individuals. **Current recommendation**: Ensure and document that individuals receive adequate assistance when they transition to the new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	**Compliance:** Partial.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** MSH tracks and monitors individuals whose length of stay exceeds six months, through monthly reviews by team representatives and program managers. **Current recommendation**: Continue current practice.
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated,	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** MSH conducts reviews via the monthly meetings of team

	appropriate placement as clinically and legally indicated.	representatives and program managers to address obstacles to discharge on children and adolescents whose length of stay exceeds six months. **Current recommendation**: Continue current practice.

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress: **<u>Psychiatric Services</u>:** 1. DMH has finalized and updated individualized medication guidelines regarding the use of several classes of psychoactive medications. The guidelines comport with current generally accepted professional standards. MSH provided constructive feedback and adopted the finalized guidelines. 2. MSH has instituted a time limit regarding the ordering of PRN and Stat medication. 3. MSH has refined its monitoring indicators regarding medication management to ensure better alignment with EP requirements. 4. MSH has improved sample sizes in data collection. 5. MSH has developed a method to identify individual and group trends regarding high-risk medication uses. 6. MSH has developed adequate mechanisms to improve its practice regarding diagnosis and management of individuals suffering from abnormal involuntary movements. 7. MSH has revised its data collection tools and developed written instructions to staff regarding adverse drug reactions and medication variance reporting. **<u>Psychological Services</u>:** 1. MSH has developed and implemented audit tools in alignment with EP requirements. 2. Improvements are seen in PBS treatment plans and services. 3. MSH has improved PSR services provided to bed-bound individuals. 4. MSH has reduced Mall cancellations, sustained the hours of Mall service by various disciplines and has increased available enrichment, leisure and exercise activities. Additionally, there has been an increase in PSR Mall progress notes.

	5. BY CHOICE Point Cards have been prepared in multiple languages. **<u>Nursing Services</u>:** 1. The statewide Nursing Admission Assessment and Integrated Assessment are in the final stages of completion and will be implemented within weeks of this visit. 2. Nursing has added a number of competency-based trainings to their new employee orientation and as part of their annual schedule. 3. MSH has made significant progress regarding bed-bound individuals and providing activities on the units and in the individuals' rooms. **<u>Rehabilitation Therapy Services</u>:** The facility engaged in activities intended to advance towards EP compliance, but significant focused work remains to be done to achieve compliance. **<u>Nutrition Services</u>:** 1. Weight Management Protocol and Dysphagia Protocol are now part of New Employee Orientation (July). 2. Curriculums have been developed for weight management, nutrition and health, and diabetes education that are in line with PSR requirements. 3. "Solutions for Wellness" training for class facilitators has been developed. 4. Presented education regarding eating disorders for Community Outreach program. **<u>General Medical Services</u>:** 1. MSH has implemented a system of after-hours coverage by both staff physicians and surgeons and psychiatrists. 2. MSH has consolidated and refined the monitoring instruments for

	a variety of metabolic disorders. 3. MSH has refined the monitoring indicators regarding the integration of medical care into other functions of the WRPT. 4. MSH has conducted an analysis of trends and patterns regarding a variety of infectious diseases and provided adequate recommendations for corrective actions. **Infection Control:** 1. MSH has developed and implemented a number of monitoring instruments in alignment with the EP. 2. Initial data have been generated regarding the monitoring and tracking of infections and communicable diseases. **Dental Services:** 1. The dental departments have been collaborating regarding dental software programs and should have a program selected within the next 6 months. 2. The facility is beginning to put systems in place to address the individuals' refusals for dental appointments and treatments. **Special Education:** 1. MSH has made progress in the development and use of assessment tools (Psycho-Educational Assessment Audit, Individual Education Plan Audit Interview, Individual Education Plan Meeting Audit, and Individual Education Plan Review Tool). 2. MSH has developed an appropriate and ambitious professional development schedule directly associated with recommendations of this report. 3. MSH has taken a developmental approach to providing training to staff in using curriculum-based measurement to monitor student progress.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Michael Barsom, MD, Acting Medical Director 2. Nady Hanna, MD, President of Medical Staff 3. Bala Gulasekaram, MD Chief of Psychiatry Department 4. Harold Plon, PharmD, Assistant Director of Pharmacy Department 5. Christopher Heh, MD, Chief of Professional Education and Chair, Pharmacy and Therapeutics (P&T) Committee 6. Bruce Abrams, MD, Senior Psychiatrist and member, P&T Committee 7. Anita Sobolewska, RN, Nursing Performance Improvement Coordinator Reviewed: 1. The charts of 42 individuals: JEH, JC, GCS, PRQ, RM, MJR, JM, LW, TS, EG, ABW, MW, LLW, JWC, TMS, GCS, SMA, WP, FDA, WH, ESD, MRC, GP, AF, LW, MP, NMV, BKW, AB, MEB, CZ, GWB, TB, PC, EW, JLM, TS, HM, JGH, KV, TP and RH 2. DMH Psychopharmacology Guidelines (June 13, 2007) 3. MSH Pharmacy Bulletin, June 2007 4. MSH Recommendations for Changes of DMH Psychotropic Medication Policies (May 2007) 5. MSH Psychiatric Physician's Manual 6. E-mail from the Medical Director (August 24, 2007) regarding time limit on ordering of PRN medications 7. Nursing Policy and Procedure #528, PRN Orders (regarding 14-day stop order) 8. MSH Psychiatric Evaluation Monitoring Form 9. MSH Psychiatric Evaluation Monitoring summary data (July 2007) 10. MSH Monthly Progress Notes (Psychiatry) Monitoring Form 11. MSH Monthly Progress Notes (Psychiatry) Monitoring summary

		data (March to July 2007) 12. DMH Nursing Services: PRN/Stat Medications Monitoring Forms 13. Nursing Services: PRN/Stat Medications Monitoring summary data (March to July 2007) 14. Psychiatry Stat Medication Monitoring Form 15. Psychiatry Stat Medication Monitoring summary data (July 2007) 16. MSH Psychopharmacology Monitoring (Polypharmacy) Form 17. MSH Psychopharmacology Monitoring (Benzodiazepine) Form 18. MSH Psychopharmacology Monitoring (Anticholinergic) Form 19. MSH New-generation Antipsychotic Medications Monitoring Form 20. MSH revised Policy and Procedure, Tardive Dyskinesia (TD), (effective August 1, 2007) 21. DMH DUE Benzodiazepine Auditing Form 22. DMH DUE Benzodiazepine Auditing Form Instructions 23. DMH DUE Anticholinergic Auditing Form 24. DMH DUE Anticholinergic Auditing Form Instructions 25. MSH Policy and Procedure, Tardive Dyskinesia (effective August 1, 2007) 26. MSH TD Monitoring Form 27. MSH TD Monitoring summary data 28. MSH TD Database 29. MSH Policy and Procedure, DUE (effective August 2007) 30. Nursing policy and procedure #500, Medication Administration 31. MSH ADR Reporting Form (revised August 30, 2007) 32. MSH ADR Policy and Procedure (effective July 24, 2007) 33. MSH Guidelines for Completing the ADR Reporting and Monitoring Form (effective August 30, 2007) 34. Summary reports of ADRs since January 1, 2007 35. Last three completed ADR reports 36. MSH revised Medication Variance & Monitoring Reporting Form 37. AD for Medication Variance (undated) 38. MSH Guidelines for Completing the Medication Variance Reporting & Monitoring Form (undated)

		39. Last ten completed Medication Variance Reports 40. Minutes of the P&T Committee Meetings on March 8, April 19, May 8, June 12 and July 24, 2007
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Finalize and implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. **Findings:** A statewide psychopharmacology committee has finalized individualized medication guidelines for use across state facilities (June 2007). The guidelines involved the use of new-generation antipsychotic medications, some mood stabilizers (divalproex and lamotrigine) and some antidepressant medications (serotonin-specific reuptake inhibitors, or SSRIs). MSH has adopted the guidelines to ensure appropriate use and for monitoring purposes. Since the initial version of the guidelines was issued (March 2007), the statewide committee has implemented updates of these guidelines that were influenced by suggestions from MSH. The updates involved the following areas: 1. Laboratory monitoring requirements regarding the use of clozapine, olanzapine, risperidone, ziprasidone and divalproex; 2. Clinical monitoring requirements regarding the use of lamotrigine; 3. Precautions/contraindications regarding the use of olanzapine and divalproex; and

		4. Therapeutic Review Committee oversight regarding upper dose limits for combinations of oral and depot formulations of the same medications. In addition, based on a review of the facility's Pharmacy Bulletin (June 2007), the upper dose limit regarding the use of paroxetine, an SSRI, has been revised. The guidelines have yet to include the use of other mood stabilizers (e.g. lithium, carbamazepine and oxcarbazapine) and antidepressants (e.g. bupropion, venlafaxine, and mirtazapine). **Recommendation 2, March 2007:** Implement recommendations listed in D.1.c, D.1.d, D.1.e and F.1.g. **Findings:** Same as in D.1.c, D.1.d, D.1.e and F.1.g. **Recommendation 3, March 2007:** Continue to monitor this requirement. **Findings:** MSH assessed its compliance with the requirements listed in F.1.a.i through F.1.a.viii using the Psychiatric Evaluation Monitoring Form (F.1.a.i and F.1.a.iii) and the Monthly Progress Notes (Psychiatry) Monitoring Form (F.1.a.i, F.1.a.ii and F.1.a.iv to F.1.a.viii). Data from the Psychiatric Evaluation Monitoring Form were based on a sample of 49% of the Integrated Psychiatric Assessments (July 2007). Using the Monthly Progress Notes (Psychiatry), the facility reviewed an average sample of 11% (March to July 2007). The facility's compliance rates, including mean rates, and monitoring indicators, as applicable, are listed for each corresponding sub-cell below. Regarding compliance with the requirement in F.1.a.viii, the facility selected several

		indicators from the Monthly Progress Notes (Psychiatry) Monitoring Form. Although these indicators are appropriate to the requirement, the facility should use the average of compliance rates from all previous sub-cells to assess compliance with this item. **Compliance:** Partial. **Current recommendations:** 1. Implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. 2. Same as in D.1.c, D.1.d, D.1.e and F.1.g. 3. Continue to monitor this requirement.
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	Integrated Psychiatric Assessment: *Diagnostic formulation:* 50%; *Included the diagnostic criteria for the given diagnose*: 55%; *Identified target symptoms:* 23%; *Reasons for continuing the medications individual came with*: 23%; and *Rationale for PRN: 50%*. Monthly Progress Notes (Psychiatry): *Rationale for current psychopharmacology plan*: 90%; *Response to pharmacologic treatments*: 93%; and *Rationale for continuation of medications or proposed plans*: 89%.

F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	Monthly Progress Notes (Psychiatry): Same as above.
F.1.a.iii	tailored to each individual's symptoms;	Integrated Psychiatric Assessment: *Identified target symptoms*: 64%.
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Monthly Progress Notes (Psychiatry): Response to pharmacologic treatments: 93%; and. Pharmacologic (Rationale for continuation of medications or proposed plans: 89%.
F.1.a.v	monitored appropriately for side effects;	Monthly Progress Notes (Psychiatry): *Monitoring of side effects, including sedation*: 84%.
F.1.a.vi	modified based on clinical rationales;	Monthly Progress Notes (Psychiatry): *Rationale for current psychopharmacology plan*: 90%; *Benefits and risks of current psychopharmacologic treatment; includes benzodiazepines, anticholinergics, and polypharmacy, if applicable:* 79%; *Response to pharmacologic treatment:* 93%; *Monitoring of side effects, including sedation:* 84%; and *Pharmacologic (Rationale for continuation of medications or proposed plans):* 89%.
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Monthly Progress Notes (Psychiatry): *Monitoring of side effects, including sedation:* 84%; and *Response to non-pharmacologic treatments*: 83%
F.1.a.viii	Properly documented.	The data provided by the facility did not include an average of the above sub-cells, as it should have.

F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to monitor the use of PRN and Stat medications to ensure correction of the deficiencies noted by this monitor. **Findings:** MSH has updated the Staff Psychiatric Physician's Manual (Section 4.3.3) to include requirements regarding the appropriate use of high-risk, PRN and Stat medications. In June 2007, MSH's Medical Director gave instructions to all physicians that all PRN orders for psychotropic medications must be time-limited to no more than 14 days. Also, Nursing and Pharmacy were instructed not accept any PRN order for a psychotropic medication that is not time-limited to 14 days or less. **Recommendation 2, March 2007:** Consolidate the monitoring processes for PRN and/or STAT medications and for psychiatric reassessments (progress notes). **Recommendation 3, March 2007:** Ensure monitoring of a sample of 20% of the target population. **Findings:** MSH has implemented a system of reviews by the departments of Psychiatry and Nursing of a sample of all PRN/Stat medications ordered during the reporting month. In this system, the facility utilized the newly developed Nursing PRN and Stat Medications Monitoring Forms in addition to the Psychiatry Stat Medication Monitoring form. The Monthly Progress Notes (Psychiatry) Monitoring Form is used to review the psychiatrists' use of Stat medications. This system is aligned with requirements of the EP, but the monitoring indicators for both psychiatry and nursing can be consolidated to

		facilitate reviews while retaining the ability to segregate data as needed. The following is a summary outline of the facility's data organized by the name of each instrument. The months of monitoring (based on adequate samples), sample size, monitoring indicators and mean compliance rates are listed as follows: 1. Psychiatric Monthly Progress Notes (March to July 2007, average sample: 8%): *Rationale for PRN medications and review of rationale for ongoing PRN/Stat medications:* 64%. 2. Psychiatry Stat Medication Monitoring Form (July 2007, average sample: 64%): *A Psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication: 50%.* *The assessment shall address:* *Reason for Stat administration:75%;* *Individual's response:50%* *As appropriate, adjustment of current treatment: 0%; and* *Diagnosis: 43%.* 3. Nursing PRN Medications Monitoring Form (March to July 2007, average sample: 29%): *Nursing staff document the circumstances requiring PRN medication: 83%;* *Documentation includes interventions that were attempted prior to the administration of PRN medication: 57%;* *Nursing staff assess the Individual within one hour of the administration of the psychiatric PRN medication: 71%; and* *Nursing staff documents the Individuals response to PRN*

		medication: 60%. 4. Nursing Stat Medications Monitoring Form (March to July 2007, average sample: 39%): *Nursing staff document the circumstances requiring STAT medication: 89%;* *Documentation includes interventions that were attempted prior to the administration of PRN/STAT medication: 71%;* *Nursing staff assess the Individual within one hour of the administration of the psychiatric PRN or STAT medication: 73%; and* *Nursing staff documents the Individuals response to PRN or STAT medication*: 61%. **Other findings:** See D.1.f.i for this monitor's review of the appropriateness of PRN/Stat medication use. These reviews and other chart reviews by this monitor showed that MSH has yet to make progress in correcting the deficiencies outlined in the baseline assessment. **Compliance:** Partial. **Current recommendations**: 1. Consolidate the monitoring instruments regarding PRN and Stat medications, and report data that address EP requirements regarding each of the following: a. Psychiatric documentation of PRN medications' use. b. Psychiatric documentation Stat medications. c. Nursing documentation of PRN medications' use. d. Nursing documentation of Stat medications' use. 2. Continue to monitor the use of PRN and Stat medications based on at least a 20% sample.

		3. Provide ongoing feedback and mentoring by senior psychiatrists to ensure correction of the deficiencies noted by this monitor.
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to monitor the use of benzodiazepines, anticholinergics and polypharmacy, based on DMH medication guidelines (yet to be finalized). Ensure that the justification of use is consistent with current generally accepted standards. **Recommendation 2, March 2007:** Ensure monitoring of a 20% sample. **Findings:** MSH used the Psychopharmacology Monitoring Forms regarding the use of benzodiazepines, anticholinergics and polypharmacy to assess compliance with this requirement. The facility refined its data gathering and presentation to ensure better alignment with requirements of the EP. The number of charts reviewed (n) varied for each indicator depending on whether the indicator was applicable. The following is an outline of the monitoring indicators, average sample size and mean compliance rates relevant to the requirement: **Benzodiazepines** (May to July 2007, average sample: 16%): 1. *Documentation justifies regular use of benzodiazepine for anxiety or other diagnosis/indication*: 68%. 2. *Benzodiazepines used for more than two months continuously clearly document in PPN the risks of*: a. *Sedation*: 29%. b. *Drug dependence*: 29%. c. *Cognitive impairment*: 32%. d. *Gait unsteadiness*: 0%.

		e. *Respiratory depression (for those with underlying respiratory problems e.g. COPD):* 33%. f. *Toxicity if used in individuals with liver impairment (long-acting) agents*: 0%. g. *TRC consult approval obtained*: 21%. 3. *Benzodiazepine used for individuals with alcohol/drug use problems justified in PPN*: 25%. 4. *Benzodiazepine used for individuals with cognitive disorders in PPN*: 22%. 5. *Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk*: 48%. **Anticholinergics** (May to July 2007, average sample: 17%): 1. *Documentation in the physicians' progress notes (PPN) justifies regular use of anticholinergics*: 53%. 2. *Documentation includes extrapyramidal (EPS) indications*: 53%. 3. *Documentation justifies regular use for non-EPS indications*: 37%. 4. *Anticholinergic use continuously for more than two months clearly documents in PPN risks of:* a. *Cognitive impairment:* 22%. b. *Sedation (if using antihistamine):* 33%. c. *Gait unsteadiness (falls) for individuals above 60 on antihistamine:* 0%. d. *Blurred vision, constipation, urinary retention:* 9%. e. *Worsening of narrow angle glaucoma, if present:* 8%. f. *Substance abuse (especially trihexyphenidyl):* 9%. g. *Worsening of TD if present:* 9%. h. *TRC approval obtained*: 11%. 5. *Anticholinergic use in individuals (over 60) and/or individuals with cognitive disorder (regardless of duration) includes that addresses the risk of:* a. *Cognitive impairment: 0%.* b. *Sedation (if using antihistamine): 0%.*

		c. *Gait unsteadiness/falls (for individuals on antihistamine): 0%.* d. *Blurred vision, constipation, urinary retention: 33%.* e. *Worsening of narrow angle glaucoma, if present: NA (in charts* reviewed). 6. *Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk*: 42%. **Polypharmacy** (May to July 2007, average sample: 20%): 1. *Target symptoms clearly identified:* 71%. 2. *Documentation in PPN justifies the need for inter-class polypharmacy*: *44%*. 3. *Documentation in PPN justifies the need for intra-class polypharmacy*: 39%. 4. *Documentation in PPN elucidates the risks of polypharmacy:* 24%. 5. *Polypharmacy use modified in a timely manner to ensure proper indications and minimize risk:* 46%. 6. *TRC consult obtained if use exceeded 60 days:* 30%: **Recommendation 3, March 2007:** Address and correct factors related to low compliance. **Findings:** MSH reportedly intends to implement a system to ensure feedback by the senior psychiatrists and responses by the unit psychiatrist regarding prescribing practices as well as notification of the Chief of Psychiatry and the Medical Director regarding these communications. **Recommendation 4, March 2007:** Consolidate the process of monitoring of all drug uses within the Drug Utilization Evaluation (DUE) Process. **Findings:** MSH has refined the monitoring forms for each of the high-risk

		medication classes (anticholinergics, benzodiazepines, new-generation antipsychotics, polypharmacy) to improve alignment with the DMH psychotropic medication policy and with requirement of the EP. **Recommendation 5, March 2007:** Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. **Findings:** MSH has developed a methodology to identify individual and group patterns and trends regarding high-risk medication uses based on the monitoring data. According to the facility, group patterns and trends will be shared with the Medical Staff on a monthly basis and training needs will be identified and provided accordingly. Individual trends and patterns will be added to the Physician Performance data and will be addressed by the Chief of Psychiatry and Senior Psychiatrists directly with the physicians semi-annually. MSH has analyzed data regarding the use of PRN and Stat medications, benzodiazepines, anticholinergics polypharmacy (two or more intra-class and four or more inter-class medications) and new-generation antipsychotic medications. Review of the facility's data revealed the following positive trends: 1. A downward trend (June 2006 to June 2007) in the number of individuals who have required the administration of two or more PRNs in 24 hours, two or more Stat medications in 24 hours, three or more Stat medications in seven consecutive days and 15 or more Stat medications in 30 consecutive days; 2. An upward trend (June 2006 to June 2007) in the rate of individuals receiving new-generation antipsychotic medications. The facility's data showed the following trends that were either

		unremarkable or somewhat negative: 1. A mild upward trend in the use of intra-class and inter-class polypharmacy (the data do not address the justification of use); and 2. A stable trend regarding the use of benzodiazepines (December 2006 to July 2007); and 3. A mild upward trend regarding the use of anticholinergics (December 2006 to July 2007). MSH has yet to provide data-based corrective actions and/or educational activities. **Other findings:** DMH has developed monitoring instruments for use across state facilities. The DMH DUE Benzodiazepines Auditing Form and Anticholinergic Auditing Form are accompanied by instructions. The forms and instructions are aligned with requirements of the EP. The monitoring instructions address the regular use for less than as well as more than two months for all individuals. The EP requires monitoring only for regular use of more than two months unless the individual is elderly, is cognitively impaired, and/or has a substance use disorder. Review of the facility's databases showed that the facility has maintained its recent practice of reducing the number of individuals diagnosed with polysubstance dependence who are receiving long-term treatment with lorazepam. However, chart reviews by this monitor revealed that too many of these individuals are still receiving long-term treatment with either lorazepam (e.g. JEH, JC and GCS) or clonazepam (e.g. RM, PRQ and TS) without documented justification or appropriate analysis of risks and benefits of treatment. In addition, several individuals with cognitive disorders are also receiving these

medications without appropriate clinical monitoring. The following table includes examples of this practice:

Individual	Medication	Diagnosis
JM	Lorazepam	Mild Mental Retardation
EG	Lorazepam	Dementia due to Huntington's Disease
LW	Lorazepam	Mild Mental Retardation
TS	Clonazepam	Borderline Intellectual Functioning

This monitor also found that MSH has maintained an overall decrease in the number of individuals with diagnoses of cognitive disorders who are receiving unjustified long-term treatment with anticholinergic agents. However, examples of unjustified long-term use were found in several charts as illustrated in the following table:

Individual	Medication	Diagnosis
JM	Diphenhydramine and chlorpromazine	Mild Mental Retardation
LLW	Benztropine	Vascular Dementia with Delusion
ABW	Trihexyphenidyl	Cognitive Disorder, NOS
MW	Diphenhydramine	Borderline Intellectual Functioning

In reviewing the charts of individuals receiving polypharmacy, this monitor found examples of inadequate documentation of justified treatment and/or attempts to simplify treatment and/or use safer alternatives (e.g. FDA, WH, TMS, AB and ESD).

Compliance:
Partial.

Current recommendations:
1. Continue to monitor the use of benzodiazepines, anticholinergics

		and polypharmacy, based on DMH medication guidelines and ensure at least a 20 % sample of the target population. 2. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance. 3. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new-generation antipsychotic medications.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as in F.1.a. **Findings:** Same as in F.1.a **Recommendation 2, March 2007:** Same as in F.1.g. **Findings:** Same as in F.1.g. **Other findings:** MSH assessed its compliance with this requirement using monitoring indicators that were aligned with the DMH individualized medication guidelines. Using these indicators, the facility reviewed the use of aripiprazole, clozapine, olanzapine, quetiapine, risperidone and ziprasidone. The average sample was 21% of all individuals taking the specified medication. The number of charts reviewed (n) varied depending on whether the indicator was applicable. Monitoring was conducted in July 2007. The following is an outline of the monitoring indicators and the mean compliance rates for each medication:

	Arip	Cloz	Olan	Quet	Risp	Zip	Mean
N	85	37	177	165	198	55	
n (when listed in parentheses, n represents the number of charts reviewed to which the indicator was applicable).	18	8	36	32	37	15	
%S	21	22	20	19	19	27	
%C							
1. Family/personal risk factors addressed in PPN (if medication started within last 90 days)	40 (10)	0 (1)	67 (15)	21 (14)	0 (8)	40 (5)	**36**
2. Justification for use documented in PPN for individuals with diagnosis of (for olanzapine, risperidone and quetiapine)							
Dyslipidemia	NA (0)	NA (0)	56 (9)	5 (21)	14 (21)	NA (0)	**19**
Diabetes	NA (0)	NA (0)	0 (4)	0 (10)	12 (25)	NA (0)	**14**
Obesity	NA (0)	NA (0)	45 (11)	7 (15)	0 (12)	NA (0)	**15**
3. Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia.	NA (0)	NA (0)	NA (0)	NA (0)	100 (2)	NA (0)	**100**
4. Appropriate monitoring for postural hypotension for individual >60y/o with BP<90/60 on quet	NA (0)	NA (0)	NA (0)	NA (0)	NA (0)	NA (0)	**NA**
5. ECG within previous 12 months.	61 (18)	63 (8)	36 (28)	52 (31)	54 (37)	57 (14)	**51**
6. Appropriate baseline and regular monitoring of:							
a. Body Mass Index	44 (18)	50 (8)	87 (30)	56 (32)	46 (37)	79 (14)	**60**
b. Waist Circumference	NA	NA	NA	NA	NA	NA	**NA**

			(0)	(0)	(0)	(0)	(0)	(0)	
		c. Fasting Blood Sugar (FBS) monthly (if started olanzapine or clozapine w/in last 6 months)	NA (0)	100 (2)	68 (22)	NA (0)	50 (2)	NA (0)	**69**
		d. FBS quarterly (including olanzapine and clozapine after first 6 months)	83 (18)	100 (6)	79 (29)	88 (32)	81 (37)	86 (14)	**84**
		e. Triglycerides	61 (18)	75 (8)	73 (30)	81 (32)	73 (37)	86 (14)	**75**
		f. Cholesterol	61 (18)	75 (8)	73 (30)	81 (32)	73 (37)	86 (14)	**75**
		g. HgbA1C if FBS high	100 (1)	50 (2)	25 (4)	80 (10)	79 (14)	60 (5)	**69**
		h. Prolactin level	28 (18)	0 (7)	3 (30)	13 (32)	6 (35)	14 (14)	**10**
		i. Breast exam	100 (18)	38 (8)	80 (30)	75 (32)	84 (37)	79 (14)	**80**
		j. AIMS exam	94 (18)	88 (8)	90 (29)	81 (32)	86 (35)	71 (14)	**85**
		7. Serum amylase/lipase (if on clozapine, olanzapine, risperidone)	NA (0)	13 (8)	0 (30)	NA (0)	5 (37)	NA (0)	**4**
		8. PPN documentation of potential and actual risk for each medication used.	56 (18)	50 (8)	43 (30)	6 (32)	19 (37)	43 (14)	**30**
		9. Treatment modified in an appropriate and timely manner to address identified risks	100 (6)	100 (3)	60 (15)	67 (12)	6 (18)	100 (3)	**53**

The facility recognized the low compliance rate regarding laboratory testing of prolactin and serum lipase and amylase levels. As a corrective measure, the MSH admission and annual blood panels now include these tests.

This monitor reviewed the charts of 10 individuals who are receiving new-generation antipsychotic agents and many of whom are diagnosed with a variety of metabolic disorders. The following table outlines the

initials of the individuals, the medication used and the documented metabolic disorder:

Individual	Medication (s)	Diagnosis
GP	Clozapine & quetiapine	Diabetes Mellitus
AF	Clozapine	Diabetes Mellitus, Hyperlipidemia & Obesity
LW	Olanzapine & risperidone	Diabetes Mellitus
MP	Risperidone and quetiapine	Diabetes Mellitus & Hyperlipidemia.
NMV	Quetiapine & ziprasidone	Diabetes mellitus and Diabetic Nephropathy
BKW	Quetiapine & fluphenazine	Diabetes Mellitus
AB	Clozapine	Diabetes Mellitus and Dyslipidemia
MEB	Risperidone	Diabetes Mellitus
CZ	Risperidone	Diabetes Mellitus
GWB	Risperidone	Borderline Diabetes

The reviews indicate that, in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs of individuals at risk. However, deficiencies exist in the documentation of dyslipidemia as a diagnosis despite supporting laboratory findings (AF and NMV), laboratory monitoring of prolactin levels when required (MP), clinical monitoring of the endocrine risks in female individuals (MP), physician documentation of significant laboratory abnormalities (AF) and risks and benefits of use and of attempts to use safer treatment alternatives (in most charts). In addition, the WRPs did not include interventions for individuals who repeatedly refused laboratory testing (MEB).

		Compliance: Partial. **Current recommendations**: 1. Same as in F.1.a and F.1.g. 2. Continue to monitor this requirement using at least a 20% sample.
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure accuracy of the TD database. **Findings:** MSH has revised its protocol for the diagnosis and management of Tardive Dyskinesia (TD). This monitor's review of the revised procedure showed that the facility has developed adequate mechanisms to improve its practice in the following areas: 1. Identification of individuals with involuntary movement disorders; 2. Follow-up by the TRC, neurology and the TD clinic of individuals with TD; 3. Regular monitoring of all individuals who have been identified to have TD; 4. Data analysis and corrective actions regarding results of TD monitoring. MSH has yet to implement the revised procedure. The facility has revised its TD monitoring tool to align the process of monitoring with the facility's revised procedure. The revised instrument includes the following additional indicators:

		1. Objectives and interventions were developed (to address TD); 2. A neurology consult was completed; 3. A TRC consult was completed every six months, if applicable; 4. The individual was referred to the TD clinic. This monitor's review of the current TD database revealed two instances that required correction of the database. Upon discussion with the Medical Director and the President of the Medical Staff, these corrections were implemented promptly and an adequate explanation was provided by the facility as to the reason for the discrepancy. **Recommendation 2, March 2007:** Address (and correct) factors related to low compliance. **Findings:** MSH facilitated in-service training on AIMS on August 22, 2007. The training was provided by Edmund Pi, MD, Professor of Psychiatry at USC. The facility anticipates improved practice as a result of this training and the implementation of the revised procedure. **Recommendation 3, March 2007:** Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation. **Findings:** Senior Psychiatrists were given the updated list of individuals with a positive AIMS and/or diagnosis of TD and were instructed to ensure that this recommendation is implemented. This monitor's findings are reviewed under other findings below. **Recommendation 4, March 2007:** Ensure that TD is recognized as one of the foci of hospitalization and

		that appropriate objectives and interventions are identified for treatment and/or rehabilitation. **Recommendation 5, March 2007:** Continue to monitor this requirement. **Findings:** MSH used the revised Tardive Dyskinesia Monitoring Form to assess compliance. The form has indicators that address recommendation #1. The facility reviewed all individuals identified in its TD database (July 2007). The following is an outline of the relevant monitoring indicators and corresponding compliance rates: 1. *Do monthly progress notes for past three months regarding prescribed antipsychotic medications discuss tolerability of the medication?* : 29%. 2. *If a conventional antipsychotic is used, is there evidence in PPN of justification (for) using the older generation medication?* : NA. 3. *Was an AIMS examination done on admission?* : 100%. 4. *Was an annual AIMS examination done at time of last annual physical examination?* : 100%. 5. *If this (individual) has TD, was a new AIMS examination done every three months?* : 0%. 6. *If this individual has a history of TD, was an AIMS (examination) done every three months?* : 100%. 7. *Do monthly progress notes for the three months indicate that antipsychotic treatment has been modified for individuals with TD, a history of TD, or positive AIMS test to reduce risk?* : 15%. 8. *Was a diagnosis of TD listed on Axis I and/or Axis III?* : 14%. 9. *Was TD included as a Focus in Domain VI?* : 14%. 10. *Were objectives and interventions developed?* : 14%. 11. *Was a neurology consult completed?* : 14%. 12. *Was a TRC consult completed every six months (if applicable)?* :

		50%. 13. *Was individual referred to TD clinic?* : NA. **Other findings:** This monitor reviewed the facility's database regarding individuals with positive AIMS/diagnosis of TD. This monitor reviewed the charts of nine (out of 14) individuals (TB, PC, EW, JLM, TS, HM, JGH, TP and RH) who were identified in the facility's database. The reviews showed the following pattern of deficiencies: 1. The WRP did not identify the movement disorder as a diagnosis or focus or provide any objectives/interventions to address the individuals' needs (HM, PC, JLM, HM, RH and RH). 2. The WRP identified the movement disorder as a diagnosis but did not include corresponding focus and objectives/interventions (EW). 3. The WRP identified the movement disorder as a diagnosis and focus, but did not provide corresponding objectives/interventions (JGH) 4. The WRP included an objective regarding the movement disorder that was not attainable for the individual (TB). 5. The WRP did not include any interventions that provide treatment or rehabilitation for the individual's diagnosis of TD (TB). 6. There is discrepancy between the information in the WRP and the corresponding psychiatric documentation regarding the presence of a movement disorder (TS). 7. The psychiatry progress notes did not address the movement disorder and/or results of abnormal AIMS in the chart (PC, JLM, HM and EW). 8. The psychiatric documentation appears to indicate evidence of delayed detection of TD (JLM).

		Compliance: Partial. **Current recommendations**: 1. Implement revised protocol for the diagnosis and management of TD, including follow-up at the TD clinic. 2. Standardize the TD monitoring form for use across state facilities. 3. Provide feedback and mentoring by senior psychiatrists to correct the deficiencies outlined above. 4. Monitor this requirement based on a 100% sample.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Revise the data collection tool to include the newly adopted Naranjo algorithm. **Findings:** The facility has revised the ADR monitoring form according to the Naranjo algorithm, but the revised form has yet to be implemented. The Medical Staff was instructed and provided with in-service training by Harold Plon, PharmD on August 1, 2007 regarding the newly revised ADR form and the Naranjo algorithm. Nursing staff is scheduled for training. **Recommendation 2, March 2007:** Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs. **Findings:** MSH has yet to implement this recommendation. During the first two quarters of 2007 (January 1 to June 30, 2007), MSH reported only 13

		ADRs. This represents a significant decrease in reporting compared to the last two quarters of 2006 (32 ADRs were reported). The facility anticipates that current efforts to educate staff about the non-punitive nature of this process and to raise their awareness will result in improved reporting. **Recommendation 3, March 2007:** Develop a policy and procedure regarding ADRs that includes an updated data collection tool. The procedure and the tool must correct the deficiencies identified in the baseline assessment. **Findings:** MSH has developed the policy and procedure (July 24, 2007) based on the updated data collection tool. In addition, the facility completed guidelines to the clinical staff (August 30, 3007) regarding proper methods in reporting ADRs. The facility has yet to implement its procedure and guidelines. **Recommendation 4, March 2007:** Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. **Findings:** MSH has a plan to utilize the newly installed software system (PLATO) to implement this recommendation using the new data collection tool. The facility anticipates implementation in October 2007. **Recommendation 5, March 2007:** Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.

		Findings: MSH has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Implement revised ADR data collection tool, policy and procedure and written instructions to staff. 2. Increase reporting of ADRs. 3. Implement plan to improve current tracking log and data analysis systems to provide an adequate basis for identification of patterns and trends of ADRs. 4. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as Recommendation 1 in F.1.a. **Findings:** Same as in F.1.a. **Recommendation 2, March 2007:** Develop and implement a DUE system based on established individualized medication guidelines. **Recommendation 3, March 2007:** Ensure systematic review of all medications, with priority given to

		high-risk, high-volume uses. **Findings:** MSH has developed a policy and procedure on DUE (August 2007). The procedure is based on the statewide individualized guidelines and requires review of a sample of at least 20%. This procedure does not clearly state that both high-risk and high-volume medications are prioritized for review and that a calendar for review of all medications shall be established by the facility. The facility has yet to implement DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. These elements provide the basis for performance improvement and are essential in any DUE. **Recommendation 4, March 2007:** Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, the sample size, and acceptable thresholds of compliance. **Findings:** MSH has developed and implemented a methodology to review all medication classes with priority for the high-risk medication classes. The individualized medication guidelines include DUE monitoring instruments that outline the indicators and acceptable thresholds of compliance. The facility has yet to complete DUEs based on the data derived from this process. **Recommendation 5, March 2007:** Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and

		current professional practice guidelines. **Findings:** As mentioned in F.1.a., the DMH Statewide Psychopharmacology Committee has updated the guidelines. The updates were influenced by appropriate feedback from the Medical Staff at MSH. **Compliance:** Partial. **Current recommendations**: 1. Revise current DUE policy and procedure to ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 2. Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. 3. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement a policy and procedure regarding MVR that includes a revised data collection tool. The procedure and the revised tool must address the deficiencies identified in the baseline assessment report. **Findings:** MSH has developed an AD and revised its MVR data collection tool. It is unclear why the facility developed a policy and procedure for ADR

		reporting and an AD for MVR. The Medical Staff has received training regarding the use of the revised tool. Ongoing training is being provided to Nursing Staff. The revised MVR form integrated input from Nursing, Pharmacy and Medical Staff. The revised instrument has yet to be implemented. **Recommendation 2, March 2007:** Provide instruction to all clinicians regarding significance of and proper methods in MVR. **Findings:** MSH has implemented this recommendation. The facility developed adequate written guidelines for clinical staff regarding proper methods of reporting variances. MSH Medical Staff received training on August 1, 2007 regarding the new procedure. Final implementation is pending adequate training and instruction of all nursing staff. **Recommendation 3, March 2007:** Develop and implement tracking log and data analysis systems. **Findings:** Reportedly, data from the newly developed MVR monitoring forms will be entered into the PLATO database and the data will be analyzed to identify patterns and trends of MVRs. The Standards Compliance Department will report MVRs to the P&T committee every three months. The P&T Committee will analyze the reported information regarding patterns and trends of MVRs and provide recommendations. The P&T Committee will report its findings to the Medical Staff where the patterns, trends and recommendations will be discussed. **Recommendation 4, March 2007:** Provide educational programs to address trends in the occurrence of MVRs.

		Findings: MSH has yet to implement this recommendation. **Recommendation 5, March 2007:** Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. **Findings:** MSH has yet to implement this recommendation. The Medical Staff is reviewing the scope and function of several committees to determine an appropriate assignment of the intensive case analysis. **Compliance:** Partial. **Current recommendations**: 1. Implement the revised MVR form and written instructions to staff and develop a policy/procedure to codify this system. 2. Develop and implement tracking log and data analysis systems. 3. Provide educational programs to address trends in the occurrence of MVRs. 4. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines,	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as in F.1.a through F.1.h.

	anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Findings:** Same as in F.1.a through F.1.h. **Recommendation 2, March 2007:** Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use. **Findings:** The facility has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations:** 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Compliance:** Non-compliance. **Current recommendations:** Same as above.

F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Compliance**: Non-compliance. **Current recommendations:** Same as above.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h. **Findings:** Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in D.1.b., D.1.c., D.1.f.viii. and F.1.a. through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.

F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, March 2007:** Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the psychiatry department. **Findings:** MSH has yet to implement this recommendation. **Current recommendations**: 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the psychiatry department.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.

F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendations**: Same as F.1.e.

F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new-generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations:** Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as in C.2.o, F.1.c and F.1.m.iii. **Findings:** Same as in C.2.o, F.1.c and F.1.m.iii. **Compliance:** Partial. **Current recommendations:** Same as in C.2.o, F.1.c and F.1.m.iii.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure full and consistent compliance with this requirement. **Findings:** MSH has yet to implement this recommendation. During the past year, 25% of the psychiatrists did not meet the requirement.

		Compliance: Partial. **Current recommendations**: Ensure full and consistent compliance with this requirement.

2. Psychological Services		
		Methodology: <u>Interviewed</u>: 1. Ten individuals: LP, NV, AH, AB, LR, AB, RRC, JY, QV, and FG 2. Swati Roy, PhD, Chief of Psychology, C-Chair of BCC 3. Edwin Poon, PhD, Psychologist 4. Kirk Hartley, PhD, Psychologist 5. Ashwind Singh, Psychology Intern 6. Susan Shifflett, Psychology Intern 7. Ana Peeks, PsyD, Psychologist 8. Leora Scheffres, PhD, Psychologist 9. Cindy Huang, PhD, Psychologist 10. Steve Young, PsyD, Psychologist 11. Brian Hough, PhD, Senior Psychologist 12. Wilma Fuentes, RN, PBS Team Member 13. Bo Kasperowicz, PT, PBS Team Member 14. Crystal Amey, PT, PBS Team Member 15. LaTasha Fields, PT, PBS Team Member 16. Katherine Nguyen, RN, PBS Team Member 17. Eric McMullen, PT, PBS Team Member 18. AL Munoz, PT, PBS Team Member 19. Gretchen Hunt, BY CHOICE Coordinator 20. Doug Strosnider, Mall Director, Director of Central Program Services 21. Ken Layman, Treatment Enhancement Coordinator 22. Cynthia Lush, Clinical Administrator 23. Kenny Bert, Assistant program Director 24. Fatimah Busran, MSW, Social Worker 25. Lee Breitenbach, CSW, Social Worker 26. James Park, CSW, Social Worker 27. Shirin Karimi, LCSW, Chief of Social Work 28. Sonya Rock, ACSW, Social Worker

		29. Jocelyn Agtarap, Nurse 30. Renee Kelley, Program Director, Program 6 31. Mary Uribe, PT 32. Gordon Wallin, PSW 33. Donald Magner, PT Mall Coordinator 34. Don Pieratt, PT, BY CHOICE Coordinator, Program V 35. Renee Mathis-Ryan, RT 36. Massha Jordan-Woods, RT <u>Reviewed</u>: 1. Charts of 35 individuals: AF,CG, CK, DM, DY, FR, GD, GF, GG, IG, JG, JM, JS, KH, KM, KR, KS, LA, MC, MF, ML, MP, NH, NR, PT, PW, RA, RL, RM, RR, RV, SFY, TD, TP, and TS 2. Completed PBS-BCC Checklist 3. Behavioral Consultation Committee Recommendation Reports 4. Positive Behavior Support Plans 5. List of Individuals by Program/Unit, Needing Behavioral Interventions 6. List of High Utilizers of Seclusion and Restraints 7. Staff training documentation on PBS plans 8. Psychologist Performance Review 9. Statewide Positive Behavior Support Plan Monitoring Form 10. Structural and Functional Assessments 11. Questions About Behavioral Function in Mental Illness (QABF-MI) data 12. Procedures Steps for Behavioral Consultation Committee Form 13. Strength-Based Conversations Form 14. Mall Weekly Lesson Plans (Recovering From Mental Illness, Coping Skills, Mental Health Awareness, Leisure Activities, Welcome to Reality, Fun with Music, Cognitive Skills Memory, Reminiscing, and Cognitive Skills Training) 15. Neuropsychological Services Tracking Database 16. Psychologists Weekly Monitoring and Mentoring Log

		17. List of Individuals 22 Years Old and Younger 18. List of Individuals on PBS Plans 19. BY CHOICE Staff Competency Audit Report 20. BY CHOICE Monitoring Form and Instructions: Competency and Fidelity Check 21. Curriculum for bed-bound individuals 22. Program by Unit by Assessment Completed/Needed 23. PBS Plan Tracking Spreadsheet 24. Staff Competency and Training Record <u>Observed</u>: 1. Five WRP Conferences: RJ, Unit 407, Program 5; JP, Unit 419, Program 6; JB, Unit 415, Program 111; MA, Unit 415, Program 3; and CD, Unit 407, Program 5 2. Five PSR Mall Groups: Stay Tuned, Bed-Bound Unit 418 and 419; Drug Education Program, Substance Recovery, Unit 409, Program 3; Communication Through Music, Unit 420, Program 6; Bridge to Recovery, Unit 409, Program 3; and Conflict Resolution, Unit 405, Program 5
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendations:** **Recommendation 1-2, March 2007:** 1. Ensure that all PBS psychologists use the PBS model as currently identified in the literature. 2. Provide Positive Behavior Supports training to all PBS team members. Specifically, train these members on the reliable use of evidence-based tools. **Findings:** MSH PBS teams do not have psychologists on their teams at this time. MSH PBS team members were trained (August 6 and 9, 2007) on PBS

procedures using current models by their DMH consultant, Angela Adkins, who also regularly reviews and gives feedback on PBS plans developed by PBS teams at MSH. MSH's CRIPA consultant has supplied the PBS teams with evidence-based tools. Ongoing supervision to PBS teams is being provided by Swati Roy, Chief of Psychology and Kirk Hartley, Senior Psychologist, albeit very minimal as indicated by the PBS team members.

The table below showing the composition of the two PBS teams and their disposition is a summary of the facility's data.

Positive Behavior Support Team Roster:

Discipline	Team 1	Team 2
Psychologist	Vacant[1]	Vacant[1]
Registered Nurse	Wilma Fuentes	Vacant[2]
Psychiatric Technician	Bo Kasperowicz	LaTasha Fields
Psychiatric Technician	Al Munoz	Crystal Amey
Research Analyst	Vacant[3]	Vacant[3]

Recommendation 3, March 2007:
Recruit data analysts for all PBS teams.

Findings:
The data analyst position is still vacant. MSH had reclassified the data analyst position as one of a Research Analyst to align with HR job classification categories. MSH is actively recruiting to fill the positions.

Recommendation 4, March 2007:
Ensure that PBS team members do not have other duties that conflict with their full participation in PBS activities.

		Findings: PBS team members in MSH have PBS-related activities as their primary duties. Their non-PBS activities do not interfere with their PBS activities. This monitor interviewed the Chief of Psychology and members of the PBS teams. All of them informed this monitor that their primary work is related to PBS activities. **Recommendation 5, March 2007:** Ensure that the need for Behavior Guidelines statement in the DMH Psychology Manual is written correctly. **Findings:** This monitor reviewed the DMH Psychology Manual. MSH has edited the statement on Behavior Guidelines in the DMH psychology Manual. **Recommendation 6, March 2007:** Revise the PBS-BCC Checklist to remove the Type-A and Type-B identifiers. **Findings:** This monitor reviewed the PBS-BCC checklist. MSH has removed the designation of Type-A and Type –B for behavioral plans from the PBS-BCC checklist. **Compliance:** Substantial. **Current recommendations**: 1. Ensure that all PBS psychologists use the PBS model as currently identified in the literature. 2. Provide Positive Behavior Supports training to all PBS team

<table>
<tr><td></td><td></td><td>members. Specifically, train these members on the reliable use of evidence-based tools. Recruit data analysts for all PBS teams.
3. Recruit Data Analysts for all PBS teams.</td></tr>
<tr><td>F.2.a.i</td><td>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Continue current practices of training of PBS staff members.

Findings:
MSH PBS team members were trained (August 6 and 9, 2007) on PBS procedures by their DMH consultant, Angela Adkins.

Recommendation 2, March 2007:
Conduct treatment implementation fidelity checks regularly.

Findings:
MSH used item #2 from the DMH psychological Services Monitoring Form to address this recommendation, reporting 31% compliance. The table below with its monitoring indicator showing the number of PBS plans with completed staff training (N), the number of PBS plans with fidelity checks (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>13</td><td>12</td><td></td></tr>
<tr><td>n</td><td>8</td><td>2</td><td>2</td><td>10</td><td>12</td><td></td></tr>
<tr><td>%S</td><td>62</td><td>18</td><td>18</td><td>77</td><td>100</td><td></td></tr>
<tr><td>%C-#2</td><td>8</td><td>0</td><td>50</td><td>40</td><td>58</td><td>31</td></tr>
</table>

According to Swati Roy, Chief of Psychology, the low compliance obtained was due to the non-completion of fidelity checks on PBS plans where the individual was transferred to other units or their plans were</td></tr>
</table>

		under revision, and that fidelity checks now are being collected on all active PBS plans. Fidelity checks should be conducted even if an individual is transferred to another unit as long as the plan is being implemented. Fidelity checks should also be conducted when a plan is under revision, unless the plan in force is suspended. In fact, fidelity checks should be conducted prior to establishing the need for a revision of the plan. This monitor's review of the PBS plans is in agreement with the facility's data. Fidelity scores were available for six PBS plans (DY, JG, NR, PW, KR, and FR), and the fidelity scores ranged from 100% to 37%. **Recommendation 3, March 2007:** PBS team leaders should come up with specific criteria to revise treatment plans, conduct further assessments, and to make referrals to BCC. **Findings:** MSH has established specific criteria to revise PBS treatment plans, conduct further assessments, and to make referrals to BCC. The criteria are included in the PBS instructions. The criteria include a 2-3 point change in the target behavior(s) as well as trigger data (PRN and Seclusion and Restraint). This monitor reviewed the List of High Utilizers of Seclusion and Restraints. The list contained 43 individuals. The PBS team has addressed the status of each one of these individuals through further assessment, DCAT plans, WRPT interventions, and implementation of behavior guidelines or PBS plans. **Recommendation 4, March 2007:** Ensure that all PBS team leaders receive training in the development of

		structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. **Findings:** MSH PBS teams do not have team leaders at this time. The teams do not have psychologists. MSH is actively recruiting to fill the vacancies. Meanwhile, Swati Roy, Chief of Psychology, and Kirk Hardly, Senior Psychologist, are providing supervision to the PBS teams. In addition, their DMH consultant, Angela Adkins, is providing training and reviewing PBS plans. **Recommendation 5, March 2007:** Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area. **Findings:** MSH PBS teams do not have any data analysts at this time. RNs and PTs on the PBS teams receive training from their DMH consultant, Angela Adkins. Evidence-based tools and guidelines on data collection were received through the facility's CRIPA consultant, Nirbhay Singh. Reliability checks were conducted for all PBS team members. This monitor met with the PBS team members. Most of them were able to articulate the basics of PBS principles and procedures, and they were able to discuss data-based hypothesis-building and treatment components. However, a number of them felt that they were receiving minimal supervision, and requested more advanced training, especially in treatment development **Compliance:** Partial.

		Current recommendations: 1. Continue current practices of training of PBS staff members. 2. Conduct treatment implementation fidelity checks regularly. 3. Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. 4. Ensure that all RNs, PTs and data analysts on the PBS teams receive guidelines for using evidence-based tools for referrals, training on evidence-based tools for data collection and that a team leader performs reliability checks in this area.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue with competency-based training of all staff in correctly implementing the BY CHOICE program. **Findings:** MSH has conducted competency-based training in correctly implementing the BY CHOICE program. A total of 528 staff have undergone training. Training is to continue until all staff is trained in the BY CHOICE program. This monitor reviewed the BY CHOICE staff training logs and the BY CHOICE individual training logs. As of June 28, 2007, 58% (376/646) of the individuals at MSH have received training on their BY CHOICE program. **Recommendation 2, March 2007:** Implement the program as per the manual.

		Findings: MSH has rolled out the BY CHOICE to all programs in the facility (17 units), with eight incentive stores hospital-wide. Regular hours for incentive stores are posted, and inventory is tracked monthly. The Individual Satisfaction Surveys are completed quarterly. The BY CHOICE committee meets weekly. This monitor reviewed the Individual Satisfaction Surveys. The Survey contains seven questions. Six of the questions received good ratings (around 50%) in the "Always" category. The question "Do you hold on to the point card during the day?" received the following response: 11% "Always," 7% "Most of the time," 3% "Very Little," and 6% "Never." The question, "Do staff explain how you earn a "FP", "MP", or "NP" for each activity, received "Very Little"/Never," from 19% of the respondents. **Recommendation 3, March 2007:** Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle. **Findings:** This monitor reviewed MSH's BY CHOICE Training Log. MSH continues to provide training to WRPTs and individuals on an ongoing basis. This monitor reviewed ten charts (TP, RL, MP, DY, TD, NR, RA, JM, JS, and PW). All ten of them had mention of BY CHOICE. However, very few of them had proper documentation as indicated in the WRP Manual. For example, documentation for JS stated "isn't too motivated to carry point cards," and for PW, "PSR attendance needs improvement." **Recommendation 4, March 2007:** Report BY CHOICE point allocation statement in the Present Status section of the individual's case formulation and update at every

scheduled WRPC.

Findings:
MSH used item #1- #5 from the BY CHOICE Monitoring Form to address this recommendation, reporting 15%, 6%, 10%, 10%, and 16% compliance respectively. The table below with its monitoring indicators showing the number of individuals in the facility per month (N), the number of charts audited per month (n), and the percent compliance obtained (%C) is a summary of the facility's data.

#1: *If individual is using a "baseline" or "reallocated" point card.*

#2: *Point reallocation completed.*

#3: *Rationale was provided for point reallocation or no reallocation.*

#4: *Individual provided inputs in point allocation.*

#5: *WRPT documented "continuity of care" from prior months.*

	Mar	Apr	May	Jun	Jul	Mean
N	654	666	676	675	705	
n	135	132	124	123	144	
%S	21	20	18	18	20	
%C						
%C-#1.	0	0	0	43	32	15
%C-#2.	3	7	4	7	9	6
%C-#3.	3	5	10	13	17	10
%C-#4.	3	8	7	14	20	10
%C-#5.	5	9	15	18	32	16

MSH further audited WRPCs to evaluate if BY CHOICE is discussed in the WRPC, reporting 88% compliance. The table below showing the

number of WRPC per month (N), the number of conference audited (n), and the percentage compliance obtained (%C) is a summary of the facility's data.

	Mar	Apr	May	Jun	Jul	Mean
N	654	666	676	675	705	
n	135	132	124	123	144	
%S	21	20	18	18	20	
%C	82	86	89	90	91	88

The table above shows that BY CHOICE is discussed in at least in 88% of the WRPCs. However, the extent of the entry in the Present Status section of the individuals' WRPs is poor.

This monitor reviewed 11 WRPs (CG, RV, KM, DM, TS, FR, MF, RR, LA, CK, and PW) using the same five items as MSH. Two of them met criteria (LA and DM), eight of them had brief mentions on BY CHOICE (MF, PW, KM, RV, CG, TS, FR, and RR), and one of them (CK) did not have any mention of BY CHOICE. For example, MF's BY CHOICE entry simply states, "points will remain the same. No Mall notes were in the chart at this time from the previous month". In the case of FR, it is obvious that the WRPT failed to do a good "cut-and-paste" job, the BY CHOICE point discussion starts off well, but included in the sentences were entries including "Ms. R states "……". Point allocations were discussed and Ms. R agrees/disagrees to have more points reallocated for her Mall activities". In the case of TS, the documentation in- part reads, "BY CHOICE points will be revised at the next WRPC after the team has had an opportunity to determine how we can structure incentive."

WRPTs need further training on proper documentation of BY CHOICE point allocation and discussion following the five items MSH uses to audit this recommendation.

		Compliance: Partial. **Current recommendations**: 1. Continue with competency-based training of all staff in correctly implementing the BY CHOICE program. 2. Implement the program as per the manual. 3. Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle. 4. Report BY CHOICE point allocation statement in the Present Status section of the individual's case formulation and update at every scheduled WRPC.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** MSH's Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the BY CHOICE incentive program. According to Swati Roy, the current Chief of Psychology, her responsibilities, among others, include the hiring of staff, determining their duties and responsibilities, supervising the staff, evaluating staff performance evaluations, developing and implementing policies and procedures, and evaluating program outcomes. **Compliance:** Substantial.

		Current recommendation: Continue with current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. **Findings:** MSH's PBS team members are receiving training in PBS process and procedures through their DMH consultant, Angela Adkins. PBS teams do not have psychologists or team leaders at this time. However, they continue to provide services through the training received from their DMH consultant and the supervision provided by Swati Roy, Chief of Psychology and Kirk Hartley, Senior psychologist. The PBS team members indicated that they would benefit from more advanced training, especially in the area of treatment development and case formulation. **Recommendation 2, March 2007:** Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. **Findings:** MSH is using the trigger system, WRP Foci 1 and 3, and monthly reports from unit psychologists to track individuals in need of behavioral interventions. Senior Psychologists review the monthly psychology reports for further review.

		This monitor reviewed the list of individuals on Seclusion and Restraint. PBS has addressed the needs of the individuals in the list, making recommendations including further behavioral assessment, behavioral guidelines, and PBS plans. **Recommendation 3, March 2007:** Ensure that senior Psychologists monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams. **Findings:** MSH has its Senior Psychologists review all behavioral guidelines. The Senior Psychologists review the appropriateness and effectiveness of the behavior guidelines. When appropriate, the Senior Psychologists assist the WRPTs to make a referral to PBS. However, MSH has one Senior Psychologist at this time and he is unable to attend to all the tasks in a timely manner. **Current recommendations**: 1. Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Ensure that senior Psychologists monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

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<td>Findings:
MSH used item #6 from the DMH Psychological Services Monitoring Form to address this recommendation, reporting 76%. The table below with its monitoring indicator showing the number of Functional Behavioral Assessments (N), the number of Functional Behavioral Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The hypotheses of the maladaptive behavior are based on structural and functional assessments.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>16</td><td>16</td><td>14</td><td>15</td><td>13</td><td></td></tr>
<tr><td>n</td><td>16</td><td>16</td><td>14</td><td>15</td><td>13</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C-#6</td><td>44</td><td>88</td><td>86</td><td>86</td><td>77</td><td>76</td></tr>
</table>

This monitor reviewed 12 PBS plans (JG, MC, PW, KS, AF, MP, NR, TP, KR, RM, PT, and ML). Ten of them (JG, MC, AF, MP, NR, TP, KR, RM, PT, and ML) included structural and functional assessments to derive hypothesis for the individual's maladaptive behaviors, and the structural/functional assessments of (KS and PW) were too brief.

Current recommendation:
Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</td>
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<tr>
<td>F.2.c.iii</td>
<td>There is documentation of previous behavioral interventions and their effects;</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Ensure that previous interventions and their effectiveness are documented in the behavioral assessments.</td>
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</table>

Findings:
MSH used item #7 from the DMH Psychological Services Monitoring Form to address this recommendation, reporting 42% (for May-July, 2007). The table below with its monitoring indicator showing the number of Functional Behavioral Assessments (N) for March through July 2007, the number audited (n), and the percent compliance obtained (%C) is a summary of the facility's data.

There is documentation of previous behavioral interventions and heir effects.

	Mar	Apr	May	Jun	Jul	Mean
N	16	16	14	15	13	
N	16	16	14	15	13	
%S	100	100	100	100	100	
%C-#7	0	4	21	27	77	42

Methodological differences in the audits confound the %C data in the table above. According to Swati Roy, Chief of Psychology, the audit for March and April 2007, was determined based on the documentation in the individual's WRP, and audits for May through July was based on the documentation in the Functional Behavioral Assessments.

This monitor reviewed eight charts (DY, MP, FR, PW, RL, KR, JG, and AF) previous intervention was documented in two of them (FR and RL), and was not documented in the other six (DY, MP, PW, KR, JG, and AF).

This monitor also reviewed ten functional assessments (NR, PW, MP, KR, ML, KS, AF, JG, MC, and TP). Three of them (ML, JG, and AF) had documented/discussed the individual's previous interventions and its effectiveness, and the remaining seven (NR, PW, MP, KR, KS, MC, and TP) did not have such documentation, and there was no indication if the

<table>
<tr><td></td><td></td><td>individuals had received any previous interventions.

Current recommendation:
Ensure that previous interventions and their effectiveness are documented in the behavioral assessments.</td></tr>
<tr><td>F.2.c.iv</td><td>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.

Findings:
MSH used item #8 from the DMH Psychological Services Monitoring Form to address this recommendation, reporting 100%. The table below with its monitoring indicator showing the number of individuals with PBS plans (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies.

<table>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>16</td><td>15</td><td>16</td><td>13</td><td></td></tr>
<tr><td>N</td><td>16</td><td>15</td><td>16</td><td>13</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C-#8</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
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This monitor reviewed 12 PBS plans (JG, MC, PW, KS, AF, MP, NR, TP, KR, RM, PT, and ML). The interventions in these plans were based on a</td></tr>
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		positive behavioral supports model. There was no evidence that any aversive or punishment contingencies were developed and/or implemented in these plans. MSHs Senior Psychology staff, and Administrative and Managerial staff are committed to using positive approaches in servicing individuals in MSH. **Current recommendation**: Continue current practice.
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that staff across settings is aware of individual's behavioral plan, and that they receive written plans and training. **Findings:** MSH trains and certifies staff on all PBS plans prior and during the implementation of the plans. According to the PBS team members and the Chief of Psychology, staff is trained to competency utilizing the PBS Plan with integrated behavioral drills. This monitor reviewed ten PBS plans (JG, DY, GF, AF, MC, MP, PW, RM, FR, and NR). All ten of them included staff training logs. **Recommendation 2, March 2007:** Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings. **Findings:** MSH used item #9 from the DMH Psychological Services Monitoring Form to address this recommendation, reporting 31% compliance. The table below showing the number of PBS plans with completed staff training and integrity data (N), the number of plans with integrity

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<td>checks (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Behavioral interventions are consistently implemented across all settings, including school settings.

<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>13</td><td>12</td><td></td></tr>
<tr><td>n</td><td>8</td><td>2</td><td>2</td><td>10</td><td>12</td><td></td></tr>
<tr><td>%S</td><td>62</td><td>18</td><td>18</td><td>77</td><td>100</td><td></td></tr>
<tr><td>%C-#9</td><td>8</td><td>0</td><td>50</td><td>40</td><td>58</td><td>31</td></tr>
</table>

This monitor reviewed 13 PBS plans (TP, KR, NR, RM, PW, MC, JG, ML, DY, AF, MP, FR, and RL). Five of the plans were recently developed (KR, RM, ML, AF, and MP) and not included for this audit. Four of the remaining eight plans (TP, NR, PW, and FR) were not consistently implemented.

Current recommendations:
1. Ensure that staff across settings is aware of individual's behavioral plan, and that they receive written plans and training.
2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.</td>
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<tr>
<td>F.2.c.vi</td>
<td>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
The hospital should have a system for using the trigger data to obtain PBS consultation for appropriate individuals.

Findings:
MSH uses the trigger data to obtain PBS consultations. Swati Roy,</td>
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</table>

<table>
<tr><td></td><td></td><td>Chief of Psychology, and Kirk Hartley, Senior Psychologists (both of whom supervise the PBS teams) attend trigger meetings and examine the trigger data. They sort the list of individuals who meet criteria for PBS consultation. The PBS team members use this list and work with the WRPTs to complete the BCC-PBS checklist for referral to the PBS teams. However, in the face of staffing shortage (PBS team members, Unit Psychologists, and Senior Psychologists) the process is not as effective as it can be.

Current recommendations:
Continue current practice.</td></tr>
<tr><td>F.2.c.vii</td><td>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Integrate all behavioral interventions with other treatment modalities, including drug therapy.

Findings:
MSH used item #11 from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 75% compliance. The table below with its monitoring indicator showing the number of individuals with PBS plans (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.
<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>16</td><td>15</td><td>2</td><td>1</td><td></td></tr>
<tr><td>n</td><td>13</td><td>16</td><td>15</td><td>2</td><td>1</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
</table>
</td></tr>
</table>

		<table><tr><td>%C -#11</td><td>23</td><td>0</td><td>0</td><td>50</td><td>100</td><td>75</td></tr></table> This monitor reviewed 11 PBS plans (RL, TP, AF, JG, ML, MC, DY, KR, NR, PW, and MP). None of the PBS plans integrated behavioral interventions with other treatment modalities. Target behaviors for two of them (RL and TP) involved the environment and self-care. The remaining nine (AF, JG, ML, MC, DY, JR, NR, PW, and MP) involved target behaviors whose functions included affect regulation, stress, mental illness, and emotional regulation/stress. These functions could have had input/ support/ therapy from a number of other disciplines including medicine, nutrition, occupational therapy, and PSR Mall services/individual therapy. In some cases, what appears to be environmentally/socially mediated maladaptive behavior could be secondary to biological variables, or in addition to biological variables, and should be investigated. PBS staff, conduct record review of the individual's medical/biological aspects of the behaviors, however, they do not seem to associate the information with the target behaviors and/or integrate the modalities into their treatment/intervention plans. For example, NR's record review indicated that headache, stomach pain, and discomfort are factors in NR's depression, but there was no indication of this in NR's PBS plan. In certain cases (RL), staff (Amy Choi, Psychologist) had consulted with the psychiatrist on medication for RL's depression. However, drug modification/change made as a result of the consultation was not included/ integrated into RL's PBS plan. **Current recommendation**: Integrate all behavioral interventions with other treatment modalities, including drug therapy.
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
<td>Recovery Plan;</td>
<td>Recommendation, March 2007:
Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.

Findings:
MSH used item #12 from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 88% compliance. The table below with its monitoring indicator showing the number of individuals with PBS plans (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

All Positive Behavior Support plans are specified in the objective and interventions section of the Wellness and Recovery Plan.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>16</td><td>15</td><td>2</td><td>1</td><td></td></tr>
<tr><td>n</td><td>13</td><td>16</td><td>15</td><td>2</td><td>1</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C -#12</td><td>92</td><td>75</td><td>73</td><td>100</td><td>100</td><td>88</td></tr>
</table>

This monitor reviewed seven charts (FR, KR, RL, PW, AP, JG, and MP). Six of them (FR, JR, RL, PW, AP, and AF) had mention of the individual's PBS plan in the objective/intervention sections of the WRP.

Current recommendation:
Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.</td>
</tr>
<tr>
<td>F.2.c.ix</td>
<td>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Update all PBS plans as indicated by outcome data and document it at</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>Wellness and Recovery Plan</td>
<td>every scheduled WRPC in the Present Status section of the individual's case formulation.

Findings:
MSH used item #13 from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 75% compliance. The table below with its monitoring indicator showing the number of PBS plans with completed staff training (N), the number of plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

All Positive Behavior Support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the Case Formulation in the individual's Wellness and Recovery plan.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N</td><td>13</td><td>11</td><td>11</td><td>13</td><td>12</td><td></td></tr>
<tr><td>n</td><td>13</td><td>11</td><td>11</td><td>13</td><td>12</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C-#13</td><td>61</td><td>81</td><td>81</td><td>69</td><td>83</td><td>75</td></tr>
</table>

This monitor's review of the PBS plans and charts of six individuals (KR, FR, RL, MP, JG, and AF) is in agreement with the facility's findings.

Current recommendation:
Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation.</td>
</tr>
<tr>
<td>F.2.c.x</td>
<td>all staff has received competency-based training on implementing the specific behavioral interventions for which they are</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.

Recommendation, March 2007:
Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.

Findings:
MSH used item #14 from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 31% compliance. The table below with its monitoring indicator showing the number of PBS plans with completed staff training (N), the number of plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

All staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.

	Mar	Apr	May	Jun	Jul	Mean
N	13	11	11	13	12	
n	8	2	2	10	12	
%S	62	18	18	77	100	
%C-#14	8	0	50	40	58	31

This monitor's findings through reviews of MSH's active PBS plans are in agreement with the facility's data.

Current recommendation:
Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.

F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met. **Findings:** According to the Chief of Psychology and the PBS team members, MSH's PBS team members provide PBS services full-time. However, shortage of PBS team members (psychologists and behavior data analysts) has limited the services the PBS teams can provide at this time. According to MSH, PBS team members' PBS-related tasks include the following: • Completing structured interviews and questionnaires for current PBS cases. • Completing behavior observations of individuals. • Staff training to competency. • Additional staff training as required. • Completing integrity checks. • Data collection as required by the EP. • Completing PBS-BCC checklist. • Preparing BCC packets. • BCC attendance. • BCC recommendations follow-up. • WRP attendance. • Ensuring outcome data, need for revision and other relevant information is appropriately documented in the WRP. • Collaboration with WRPT members to determine need to revise PBS plans.

		Current recommendation: Ensure that all PBS team members provide PBS services fulltime until the needs of all individuals requiring behavioral interventions is met.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. **Findings:** Same as in Findings under Recommendation 2 in F2.a.ii. **Recommendation 2, March 2007:** Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan. **Findings:** MSH has a number of individuals who are considered to be bed-bound and even a higher number of individuals whose primary language is not English. Individuals whose primary language is not English are enrolled in the BY CHOICE program, with the exception of those who refuse/choose not to participate in the program. MSH has a total of 16 (eight from Unit 418, and eight from Unit 419) bed-bound individuals who are currently not included in the BY CHOICE program. These individuals were said to be having difficulty participating in the program. This monitor reviewed the list of individuals who were not in the BY CHOICE program. In a number of individuals the reasons given for their non-participation in the BY CHOICE program include "unaware of the contingencies" or "do not understand" (for example, JW, RR, GR,

<table>
<tr>
<td></td>
<td></td>
<td>SP, HC, and GB).

The BY CHOICE Coordinator is meeting with the program representatives to discuss a plan of action.

Current recommendations:
1. Ensure that By CHOICE point allocation is updated monthly in the individual's WRP.
2. Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan.</td>
</tr>
<tr>
<td>F.2.d</td>
<td>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Hire all members of the DCAT team.

Findings:
MSH has yet to have a full team of DCAT members. The DCAT team lacks a psychologist, a social worker, and a research analyst. The table below showing the DCAT roster with the status of each discipline in the DCAT is a summary of the facility's data.

<table>
<tr><th>Discipline</th><th>Team 1</th></tr>
<tr><td>Psychologist</td><td>Vacant</td></tr>
<tr><td>Social Worker</td><td>Vacant</td></tr>
<tr><td>Registered Nurse</td><td>Katherine Nguyen</td></tr>
<tr><td>Psychiatric Technician</td><td>Eric McMullen</td></tr>
<tr><td>Research Analyst</td><td>Vacant</td></tr>
</table>

MSH is actively recruiting to fill the vacant positions.

Recommendation 2, March 2007:
Ensure that all DCAT team members receive appropriate training.</td>
</tr>
</table>

		Findings: The DCAT members receive the same training as do the other PBS team members. Training is provided by their DMH consultant, Angela Adkins. This monitor met with the DCAT members along with the other members of the PBS teams. The DCAT team members explained that they could use further training in functional assessments and intervention plans. **Compliance:** Partial. **Current recommendations:** 1. Hire all members of the DCAT team. 2. Ensure that all DCAT team members receive appropriate training.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. **Findings:** MSH is using the PBS-BCC checklist to define the sequence of steps for referrals to the BCC. According to Swati Roy, Chief of Psychology, all referrals to the BCC is determined by the PBS-BCC checklist, which outlines the sequence of steps for referrals to the BCC. This monitor reviewed MSH's list of 13 individuals referred to the BCC (TP, KR, NR, RM, PW, MC, JG, ML, DY, AF, MP, FR, and RL). All 13 of

		them had a completed PBS-BCC checklist. **Recommendation 2, March 2007:** Ensure that all standing members of the BCC attend every meeting. **Findings:** MSH informs all core BCC members one week in advance of the scheduled meeting date. Furthermore, MSH requires that BCC members who are unable to attend any one of the scheduled BCC meetings get a written excuse from the office of the ED. According to MSH's meeting record every scheduled BCC meeting has met its quorum. MSH's BCC attendance rate by discipline is given below: **Discipline** — **Attendance Record** Chief of Psychology — 100% Chief of Psychiatry — 86% (6/7) Chief of Social Work — 86% (6/7) Chief of Rehab — 100% Medical Director — 14% (1/7) Clinical Administrator — 86% (6/7) Chief of Nursing — 71% (5/7) Standard Compliance — 43% (3/7) This monitor's review of MSH's BCC attendance record is in agreement with the facility's findings. **Recommendation 3, March 2007:** Set up a system of accountability to ensure that BCC plans are properly implemented when indicated. **Findings:** MSH has arranged such that the PBS teams track and monitor implementation of the BCC recommendations. The PBS's findings are

<table>
<tr><td></td><td></td><td>submitted monthly to the WRPT and the BCC Chair.

Compliance:
Partial.

Current recommendations:
1. Use the PBS-BCC checklist to define the sequence of steps for referrals to the BCC.
2. Ensure that all standing members of the BCC attend every meeting.
3. Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.</td></tr>
<tr><td>F.2.f</td><td>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services and to fully participate in EP requirements.

Findings:
MSH currently does not have the number of neuropsychologists to meet even the current service needs of the individuals in MSH. MSH is actively recruiting to fill the positions, including a neuropsychologist competent in the Spanish language as MSH has a good number of Spanish-speaking individuals. MSH has the service of two neuropsychologists. The table below shows that neuropsychological evaluations generally take over two months for completion, despite the low number of referrals.

<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td></tr>
<tr><td># of Referrals</td><td>5</td><td>6</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td># of Completed Assessments</td><td>2</td><td>2</td><td>4</td><td>1</td><td>4</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td># of Completed Assessment within 2 months of referral</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
</table>

Compliance:
Partial.

Current recommendation:
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services and to fully participate in EP requirements.
</td>
</tr>
<tr>
<td>F.2.g</td>
<td>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2007:
Continue current practice.

Findings:
Psychologists at MSH have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. This authority is derived from AD#0151.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td>
</tr>
</table>

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Carmen Fayloga, RN/HSS 2. Joellyn Arce, NC in Central Nursing Services 3. Aurora Hendricks, CNS Reviewed: 1. Medical records for the following 45 individuals: SB, WH, KV, BW, VB, TB, MA, AG, MC, TM CG, JM, LW, KR, AA, DA, LM, CJ, DW, RR, JB, SH, CK, LO, ES, JG, SG, JP, TC, DM, RO, JJ, IC, ME, PL, MM, MB, AE, JU, FK, GK, JE, SV, KA, HQ 2. MSH's progress report and data 3. Medication Variance Reporting & Monitoring Form 4. Draft of NP #546, Medication Variance Report (MVR) 5. Administrative Directives for Medication Variance 6. Staff training rosters for WRP training and post-test scores 7. WRP Knowledge Assessment form 8. MSH Nursing Interventions Monitoring Form and instructions 9. MSH Nursing Services Staff Knowledge of Goals, Objectives, and Interventions Monitoring form and instructions 10. DMH Nursing Services: Shift Change Monitoring Form, instructions, and data 11. Change in Status form and instructions 12. Medication observation tracking schedule 13. NP #304.1, Individuals in Bed-Bound Status 14. DMH Bed-Bound Individuals Monitoring Form and instructions 15. Nursing orientation records 16. Therapeutic Milieu Observation Monitoring form and instructions 17. MSH Nursing Education lesson plan for Medication Administration Observed:

<table>
<tr><td></td><td></td><td>1. Shift report on Unit 410
2. Individuals on Unit 419</td></tr>
<tr><td>F.3.a</td><td>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata (“PRN”) and “Stat” medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</td><td>Compliance:
Partial.</td></tr>
<tr><td>F.3.a.i</td><td>safe administration of PRN medications and Stat medications;</td><td>Current recommendations:
1. Report data by item to ensure accurate interpretation.
2. Continue to monitor this requirement.

Findings:

The following tables summarizes MSH’s compliance data regarding PRN and Stat medications given per month (N) and the items listed in the tables.
PRN Medications Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of PRNs administered each month</td><td>689</td><td>772</td><td>840</td><td>615</td><td>669</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>231</td><td>225</td><td>186</td><td>195</td><td>193</td><td></td></tr>
<tr><td>%S</td><td>43</td><td>29</td><td>22</td><td>32</td><td>29</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#2 Nursing staff documents the circumstances requiring PRN medication.</td><td>84</td><td>86</td><td>73</td><td>89</td><td>85</td><td>83</td></tr>
<tr><td>#3 Does documentation includes interventions</td><td>70</td><td>60</td><td>53</td><td>55</td><td>62</td><td>60</td></tr>
</table>
</td></tr>
</table>

that were attempted prior to the administration of PRN medication?							
#4 Nursing staff assesses the Individual within one hour of the administration of the psychiatric PRN medication.	73	75	64	75	73	72
#5 Nursing staff documents the Individual's response to PRN medication.	63	57	55	59	66	60

Stat Medications Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = total number of Stats administered each month	261	143	167	187	206	
n = actual number of audits completed	108	69	63	58	74	
%S	41	48	38	31	36	
%C						
#2 Nursing staff documents the circumstances requiring Stat medication.	90	83	89	89	92	89
#3 Does documentation includes interventions that were attempted prior to the administration of Stat medication?	72	61	83	70	69	71
#4 Nursing staff assesses the Individual within one hour of the	66	72	75	76	77	73

		administration of the psychiatric Stat medication.						
		#5 Nursing staff documents the Individual's response to Stat medication.	60	60	59	64	64	61

Medication Administration Competency Validation Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = number of level of care nursing staff who are licensed and medication certified	389	389	389	389	389	
n = actual number of nursing staff observed during medication administration	19	51	43	53	97	
%S	5	13	11	14	25	
%C						
Administration:						
#6 Assesses Individual before administering PRN or Stat medication.	80	92	96	96	100	93
#7 Administers: correct medication,	100	100	98	100	100	100
correct dose,	100	100	100	100	100	100
to correct Individual,	100	100	100	100	100	100
by correct route	100	100	100	100	100	100
at correct time/date.	100	100	100	100	100	100
#8 Educates the Individual regarding	82	84	88	98	98	90

		medications.						
		#9 Applies principles of asepsis to medication administration.	94	92	84	76	76	84
		#10 Prepares/organizes medications no more than one hour before administration.	100	98	98	100	100	99
		#11 Identifies Individual by name and photograph to ensure correct identification.	100	100	100	100	100	100
		#12 Checks for allergies.	100	98	91	100	99	98
		#13 Measures, interprets, and records BP and pulse before administering cardiac and anti-hypertensive medication. Withholds medication as indicated.	86	98	97	98	100	96
		#14 Opens/pours medication in front of Individual.	100	98	100	100	100	100
		#15 Correctly administers crushed and liquid medications.	100	98	100	98	100	99
		#16 Checks medication with MTR three times.	83	98	93	98	99	94
		#17 Ensures that the Individual swallowed all medications.	100	98	100	100	98	99
		#18 Applies proper technique with use of safety syringes.	100	100	96	100	100	99
		#19 Ensures Individual's privacy and	100	100	98	96	99	99

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>confidentiality.</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#20 Properly administers eye/ear drops, inhalers/spray.</td><td>88</td><td>97</td><td>90</td><td>93</td><td>97</td><td>93</td></tr>
</table>
</td></tr>
<tr><td>F.3.a.ii</td><td>documentation of the circumstances requiring PRN and Stat administration of medications;</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
See tables above, item #2 regarding MSH's compliance data. From my review of 50 incidents of PRNs from 10 individuals' medical records (SB, WH, KV, BW, VB, TB, MA, AG, MC, TM), I found that 45 PRNs had adequate documentation regarding the circumstances warranting the PRN.

From my review of 40 incidents of Stat medications from 10 individuals' medical records (CG, JM, LW, KR, WH, SB, AA, TM, DA, LM), I found that 37 had adequate documentation regarding this requirement.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.a.iii</td><td>documentation of the individual's response to PRN and Stat medication.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Report data by item to ensure accurate interpretation.

Findings:
See tables in F.3.a.i, item #5 regarding MSH's compliance data. From my review of 50 incidents of PRNs from 10 individuals medical records (SB, WH, KV, BW, VB, TB, MA, AG, MC, TM), I found that 27 PRNs had</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>adequate documentation regarding the individual's response to the PRN. From my review of 40 incidents of Stat medications from 10 individuals medical records (CG, JM, LW, KR, WH, SB, AA, TM, DA, LM), I found that 21 had adequate documentation regarding this requirement.

Recommendation 2, March 2007:
Continue to monitor this requirement.

Findings:
Same as above.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.3.b</td>
<td>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
MSH is currently in the process of revising the Medication Variance Report (MVR). However, MSH is tracking the elements of this requirement. For each missing signature, title, and/or initial found on the MTRs and Controlled Medication Log, an accompanying MVR is initiated and tracked for appropriate follow-up. MSH's compliance data is in the table below.

24 Hour Medication Audit
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#5 Missing signature, title and/or initial on MTR</td><td>X</td><td>X</td><td>14</td><td>49</td><td>13</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>#6 Missing signature on Controlled Medication Log</td><td>X</td><td>X</td><td>2</td><td>0</td><td>0</td></tr>
</table>

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.3.c</td>
<td>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, March 2007:
Restructure data regarding competency for all nursing and psychiatric technicians with regard to the WRP and the Recovery Model.

Findings:
MSH has revised the Nursing Interventions Monitoring Form. Inter-rater reliability completed in July 2007 was 58%. This needs to be repeated until an acceptable level (85% or higher) is achieved. In addition, collection and reporting of monthly data on Item #6 on the nested table below will commence in August 2007. The table below summarizes MSH's compliance data with the items listed on the table.

Nursing Interventions Monitoring Form
<table>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>N = total number of Individuals</td><td>654</td><td>666</td><td>676</td><td>675</td><td>705</td><td></td></tr>
<tr><td>n = actual number of audits completed</td><td>134</td><td>136</td><td>132</td><td>136</td><td>108</td><td></td></tr>
<tr><td>%S</td><td>20</td><td>20</td><td>19</td><td>20</td><td>15</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#1 All Nursing Interventions are fully integrated into the WRP.</td><td>92</td><td>82</td><td>92</td><td>85</td><td>86</td><td>87</td></tr>
<tr><td>#2 Nursing Interventions are written in a manner aligned with the rest of</td><td>94</td><td>80</td><td>90</td><td>86</td><td>91</td><td>88</td></tr>
</table>
</td>
</tr>
</table>

		the interventions in the WRP.						
		#3 The Nursing Interventions are written in observable terms.	90	91	82	75	83	84
		#4 The Nursing Interventions are written in behavioral terms.	70	78	80	75	81	77
		#5 The Nursing Interventions are written in measurable terms.	74	70	66	66	66	68
		#6 Nursing Interventions include proactive interventions related to the Individual's needs.	X	X	X	X	X	X
		#7 There are no separate nursing care plans other than the interventions integrated in the WRP.	84	67	80	82	83	79
		#8 There are no nursing diagnoses other than as specified in the WRP in terms of the current DSM criteria.	83	70	79	81	83	79

From my review of 30 individuals' WRPs (CJ, JM, DW, RR, JB, SH, CK, LO, ES, JG, SG, JP, TC, DM, TM, RO, JJ, IC, ME, PL, MM, MB, AE, JU, FK, GK, JE, SV, KA, HQ), I noted that nursing had a significant number of interventions in a variety of Foci, not just Focus 6. However, there were a number of interventions that were merely service provisions, such as "give medications as ordered," in most of the WRPs that I reviewed. Interventions that stated that education would be provided to the individual appeared to be a one-time intervention with no connection to how this would impact the individual's lifestyle or behavior. Most of the interventions that I reviewed were not written

		in measurable terms. I did not see any separate nursing care plans or nursing diagnoses from my review. In addition, I could not determine from the documentation in the progress notes when interventions were actually implemented and how often they were provided. From my discussion with Nursing, this area needs significant improvement. The additional Wellness and Recovery training, psychiatric nursing training, and the addition of the statewide Nursing Admission and Integrated Assessments should assist nursing to write more meaningful WRP interventions. **Recommendation 2, March 2007:** Develop and implement proactive interventions related to the individual's needs. **Findings:** The facility has added item #6, Nursing Interventions, to include proactive interventions related to the Individual's needs to their monitoring instrument. Data collection regarding this recommendation will begin in August 2007. **Recommendation 3, March 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Continue testing for reliability until an acceptable percentage of agreement (85% or higher) is achieved.

<table>
<tr><td></td><td></td><td>2. Provide retraining regarding WRP interventions.
3. Continue to monitor this requirement.</td></tr>
<tr><td>F.3.d</td><td>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Restructure data to ensure accurate interpretation.

Findings:
The following table summarizes MSH's compliance data regarding nursing staffs' (N) knowledge of individuals' goals, objectives, and interventions.

Nursing Staff Knowledge of Goals, Objectives, and Interventions Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of nursing staff</td><td>553</td><td>527</td><td>527</td><td>522</td><td>524</td><td></td></tr>
<tr><td>n = actual number of nursing staff audited</td><td>130</td><td>103</td><td>109</td><td>96</td><td>89</td><td></td></tr>
<tr><td>%S</td><td>24</td><td>20</td><td>21</td><td>18</td><td>17</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#1: Nursing staff working with the Individual is able to verbalize Individual's life goals.</td><td>74</td><td>74</td><td>74</td><td>73</td><td>76</td><td>74</td></tr>
<tr><td>#2: Nursing staff is able to state one objective form selected focus.</td><td>85</td><td>89</td><td>89</td><td>81</td><td>83</td><td>85</td></tr>
<tr><td>#3: Nursing staff is able to state mall services and/or interventions for this objective.</td><td>81</td><td>82</td><td>88</td><td>81</td><td>78</td><td>82</td></tr>
<tr><td>#4: Nursing staff is able to state therapeutic</td><td>79</td><td>78</td><td>82</td><td>80</td><td>80</td><td>80</td></tr>
</table></td></tr>
</table>

		milieu interventions for this objective. | | | | | | | | **Recommendation 2, March 2007:** Continue to evaluate staffing patterns to promote continuity of care. **Findings:** The facility reported that the Statewide Nursing Administrators have developed a preliminary plan for nurse staffing and will continue to address this issue. **Recommendation 3, March 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Continue to evaluate staffing patterns to promote continuity of care. 2. Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement a system for monitoring and tracking all elements of this requirement. **Findings:** MSH had been using the Shift Change Monitoring Form to address this

	State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	requirement. However, a majority of this requirement refers to chart review data, not shift change. From my discussion with Nursing, it was agreed that shift change should address a review of the status of the individuals on the unit as stated in the EP. The current shift change instrument will be revised to address this. Consequently, the data provided by MSH could not be accurately interpreted since it addressed elements that were required from the chart review. The Change in Status Monitoring Form was developed in April 2007 to capture the documentation portion of the EP data collection and reporting was initiated in May 2007. Inter-rater reliability testing completed in July 2007 showed 88% reliability. **Recommendation 2, March 2007:** Restructured data for accurate interpretation. **Findings:** The following table summarizes MSH's data obtained from the HSS logs and the items listed in the table regarding individuals who have had a change in psychiatric or medical status (N) **Change in Status Monitoring Form** See table below.

	Mar	Apr	May	Jun	Jul	Mean
N = number of Individuals identified to have changes in psychiatric and medical status	X	X	338	368	384	
n = actual number of audits completed	X	X	71	80	71	
%S	X	X	21	22	18	
%C						
#1: Change in Individual's health or mental health status is documented in a timely manner.	X	X	93	89	92	91

#2: Change in status is documented in a way that enables the Interdisciplinary Team to assess each Individual's status and response to interventions and to modify plan of care as appropriate.	X	X	86	86	93	88
#3: The documentation reflects referral to the appropriate clinician and/or team member for intervention and follow-up.	X	X	89	78	84	84

From my review of this instrument and the data, I would recommend that this instrument be expanded to include the quality and completeness of the assessments regarding status changes.

Recommendation 3, March 2007:
Continue to monitor this requirement.

Findings:
In addition, I attended a shift change report on Unit 410. Although the information shared during the report was individualized and addressed the status of each individual, there needs to be a standardized format used at each shift report to ensure consistency.

Compliance:
Partial.

Current recommendations:
1. Revise current monitoring instruments as discussed during review.

		2. Develop and implement a standardized format for shift change report in alignment with the EP. 3. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Restructure data for accurate interpretation. **Findings:** MSH has adequately restructured their data regarding this requirement. **Recommendation 2, March 2007:** Ensure that every nurse that administers medication is observed every five months. **Findings:** A tracking form was created for the Unit Supervisors to show a five-month cycle for each licensed nursing staff member assigned to their respective units. The five-month cycle shows each staff's due date for Medication Administration Competency Validation. This tracking form is given to the Nursing Department monthly. **Recommendation 3, March 2007:** Continue to monitor this requirement. **Findings:** The following table summarizes MSH's compliance data regarding

nursing administration of medication (N) and the items listed on the table measuring nursing knowledge base regarding the medications.

Medication Administration Competency Validation Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = number of level of care nursing staff who are licensed and medication certified	389	389	389	389	389	
n= actual number of nursing staff observed during medication administration	19	51	43	53	97	
%S	5	13	11	14	25	
%C						
Knowledge Base:						
#1: Verbalizes generic and trade names of medications administered.	100	98	93	94	94	96
#2: Describes therapeutic effects, usual doses, and routes of medications administered.	100	98	100	98	100	99
#3: Differentiates expected side effects from adverse reactions.	100	92	98	100	98	98
#4: Explains "sliding scale" for regular insulin.	100	98	100	100	100	100
#5: Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia.	100	96	100	100	97	99

Current recommendation:
Continue to monitor this requirement.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>F.3.f.ii</td><td>education is provided to individuals during medication administration;</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
The following table summarizes MSH's compliance data regarding nursing administration of medication (N) and the provision of medication education to the individuals.

Medication Administration Competency Validation Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = number of level of care nursing staff who are licensed and medication certified</td><td>389</td><td>389</td><td>389</td><td>389</td><td>389</td><td></td></tr>
<tr><td>n = actual number of nursing staff observed for medication administration</td><td>19</td><td>51</td><td>43</td><td>53</td><td>97</td><td></td></tr>
<tr><td>%S</td><td>5</td><td>13</td><td>11</td><td>14</td><td>25</td><td></td></tr>
<tr><td>%C
#8 Educates the Individual regarding medications.</td><td>82</td><td>84</td><td>88</td><td>98</td><td>98</td><td>90</td></tr>
</table>
Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.iii</td><td>nursing staff are following the appropriate medication administration protocol; and</td><td>Current finding on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.</td></tr>
</table>

Findings:
The following table summarizes MSH's compliance data from the Medication Administration Competency Validation Monitoring Form regarding nurses observed during medication administration (n) and the items listed on the table indicating appropriate administration protocol and practices.

Medication Administration Competency Validation Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = number of level of care nursing staff who are licensed and medication certified	389	389	389	389	389	
n = actual number of nursing staff observed for medication administration	19	51	43	53	97	
%S	5	13	11	14	25	
%C						
Administration:						
#6 Assesses Individual before administering PRN or Stat medication.	80	92	96	96	100	93
#7 Administers: correct medication,	100	100	98	100	100	100
correct dose,	100	100	100	100	100	100
to correct Individual,	100	100	100	100	100	100
by correct route	100	100	100	100	100	100
at correct time/date.	100	100	100	100	100	100
#8 Educates the	85	84	89	98	98	91

		Individual regarding medications.						
		#9 Applies principles of asepsis to medication administration.	93	93	85	96	95	92
		#10 Prepares/organizes medications no more than one hour before administration.	100	98	96	100	100	99
		#11 Identifies Individual by name and photograph to ensure correct identification.	100	98	100	100	100	100
		#12 Checks for allergies.	100	96	91	100	99	97
		#13 Measures, interprets, and records BP and pulse before administering cardiac and anti-hypertensive medication. Withholds medication as indicated.	91	98	98	98	100	97
		#14 Opens/pours medication in front of Individual.	100	98	100	100	100	100
		#15 Correctly administers crushed and liquid medications.	100	98	100	98	100	99
		#16. Checks medication with MTR three times.	89	98	94	96	99	95
		#17. Ensures that the Individual swallowed all medications.	100	98	100	100	98	99
		#18. Applies proper technique with use of safety syringes.	100	100	96	100	98	99

		#19 Ensures Individual's privacy and confidentiality. 100 100 98 95 99 98 #20 Properly administers eye/ear drops, inhalers/spray. 91 98 91 94 97 94 **Current recommendation**: Continue to monitor this requirement.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** The table below summarizes MSH's compliance data regarding observations of nursing administering medications (n) and items listed on the table addressing appropriate documentation practices.

Medication Administration Competency Validation Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = number of level of care nursing staff who are licensed and medication certified	389	389	389	389	389	
n = actual number of nursing staff observed for medication administration	19	51	43	53	97	
%S	5	13	11	14	25	
%C						
Documentation/ Completion of the MTR:						
#21: Documents reasons	89	100	100	100	100	98

for administering PRN or Stat medications.								
#22: Documents involuntary and/or emergency medication administration for PRN or Stat.	88	100	95	100	100	97		
#23: Documents effects of PRN or Stat medication within one hour.	94	96	95	100	100	97		
#24: Documents and signs out controlled medication log correctly.	100	96	94	88	99	95		
#25: Documents medication that is given on MTR immediately after administering.	100	100	98	96	100	99		
#26: Documents on MTR when medication is not taken and notifies physician.	100	95	97	97	100	98		
#27: Documents telephone order, read back, noting, and transcribing orders.	100	100	100	100	100	100		

From my review of this data and the data in cell F.3.a.i., I noted a significant difference in compliance rates regarding documentation of PRN and Stat medications. Clearly, the compliance scores are higher when nurses are being observed.

Current recommendation:
Continue to monitor this requirement.

F.3.g

Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.

Current findings on previous recommendations:

Recommendation 1, March 2007:
Separate data for Item #3 on DMH Bed-Bound Individuals Monitoring Form.

Findings:

Bed-bound Individuals Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = number of identified bed-bound Individuals each month	7	2	2	0	1	
n = actual number of audits completed	7	2	2	0	1	
%S	100	100	100	X	100	
%C	50	25	25	X	38	
#1 The Physician's Order identified the clinical reason for the bed-bound status.	0	0	0	X	100	25
#2 The WRP includes active interventions to integrate the Individual into milieu activities both in and out of room.	100	100	100	X	100	100
#3 The Physician's Progress Notes reflect clinical justification, period of commitment, and ongoing progress.	100	0	0	X	0	25
#4 The numbers of hours out in the milieu are recorded on the Daily Flow Sheet.	0	0	0	X	0	0

		From my review and observations on Unit 419, MSH has put a great deal of effort into reviewing the status of individuals who have been bed-bound. At the time of my review, there were two individuals who were determined to be bed-bound (LB and CR). In the case of CR, his bed-bound status should be temporary. Other individuals who were considered bed-bound have been evaluated and are now routinely gotten out of bed as tolerated. In addition, a number of activities are being provided in the rooms for the individuals who are not able to be up and out in the milieu. From my review, the areas of needed improvement support the MSH data. Physicians' documentation and documentation on the Daily Flow Sheet need to be addressed to achieve compliance with this requirement. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Ensure required documentation for bed-bound individuals is contained in the medical records. 2. Continue to monitor this requirement.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Partial.

F.3.h.i

mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;

Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
MSH mandates that all newly hired nursing staff complete the competency-based Nursing Orientation training/class. This mandated training/class includes mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status.

The table below summarizes MSH's compliance data for new employees (N) and completion of competency-based training in alignment with the EP.

No. of Nursing Staff Who Completed Competency-Based Training During Nursing Orientation

	Mar	Apr	May	Jun	Jul	Mean
N = total number of new nursing staff	3	2	6	2	5	
n = actual number of new nursing staff who completed competency-based Nursing Orientation training/class	3	2	6	2	5	
%S	100	100	100	100	100	
%C	100	100	100	100	100	100

Current recommendation:
Continue to monitor this requirement.

F.3.h.ii

the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and

Current findings on previous recommendations:

Recommendation 1, March 2007:
Separate the Therapeutic Milieu Observation Monitoring data to ensure nursing is promoting a therapeutic milieu and to identify training needs.

Findings:
The following table summarizes MSH's compliance data regarding the facility's units (N) and items listed on the table from the Therapeutic Milieu Observation monitoring instrument indicating the use of proactive, positive interventions.

Therapeutic Milieu Observation Monitoring Form
(Data Reflects Nursing Staff Only)

	Mar	Apr	May	Jun	Jul	Mean
N = total number of Units	17	17	17	17	17	
n = actual number of Units audited/observed	10	10	10	10	9	
%S	56	56	56	56	53	
%C						
#1: More staff are in the Milieu than in the nursing station.	90	100	90	100	100	96
#2: Staff in the Milieu are interacting with Individuals, not simply observing them.	90	90	100	100	100	96
#3: There are unit recognition programs.	78	80	70	60	67	71
#4: Positive affirmations about recovery and hope are posted throughout the unit.	50	70	70	80	67	67
#5: Unit rules are posted and reflect recovery language and	70	90	70	60	78	74

		principles.						
		#6: Unit bulletin boards are posted with religious/cultural activities.	70	70	40	60	78	64
		#7: Staff respect confidentiality.	80	80	100	90	100	90
		#8: Staff are observed offering praise or positive feedback to Individuals.	90	100	90	90	89	92
		#9: Staff are heard acknowledging Individuals' strengths and abilities.	80	80	80	80	78	80
		#10: Staff are observed responding appropriately to Individuals' requests for assistance.	100	100	100	100	89	98
		#11: Staff are observed offering choices to Individuals.	90	90	90	70	56	79
		#12: Staff are observed discussing mall activities with Individuals.	50	30	50	X	67	49
		#13: Staff use label-free language.	80	90	80	80	89	84
		#14: Staff makes use of language and terms used in Recovery Training.	50	90	70	80	89	76
		#15: Staff are actively engaged in listening.	100	100	100	100	100	100
		#16: Staff interact with Individuals in a respectful and courteous manner.	100	100	90	100	100	98
		#17: Staff encourages Individuals to help each other.	30	70	40	50	56	49
		#18: Staff encourages	60	40	40	30	56	45

		Individuals to interact with each other. | | | | | | | #19: Staff react calmly in escalating situations. | 100 | 100 | 100 | 100 | 100 | 100 | #20: Staff are observed using "Conflict Resolution" principles and techniques. | 100 | 100 | 100 | 67 | 100 | 93 | #21: Staff respect privacy. | 100 | 100 | 100 | 100 | 22 | 84 | #22: Property checks occur with respect. | X | X | 100 | X | X | 100 | #23: Staff know Individuals' Wellness and Recovery Plans. | 40 | 70 | 60 | 40 | 67 | 55 | **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Current recommendations:** 1. Develop and implement strategies and interventions to assist the nursing staff in developing therapeutic relationships with the individuals in order to effectively execute Wellness and Recovery Plans. 2. Continue to monitor this requirement.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** The following table summarizes the compliance data regarding the total

<table>
<tr>
<td></td>
<td></td>
<td>number of level of care nursing staff (N) have who received Positive Behavior Support (PBS) training.

PBS Compliance Report (**Training Category 1)
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th></tr>
<tr><td>N = total number of level of care nursing staff</td><td>719</td><td>719</td><td>719</td><td>719</td><td>719</td></tr>
<tr><td>n = number of level of care nursing staff</td><td>719</td><td>719</td><td>719</td><td>719</td><td>719</td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>%C</td><td>80</td><td>79</td><td>78</td><td>77</td><td>75</td></tr>
</table>
1 hour PBS class integrated in the Hospital Annual Update
** Training Category 1 - level of care nursing staff

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.3.i</td>
<td>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
Part of the mandated competency-based Nursing Orientation training classes includes medication administration and documentation. In addition, there is a competency-based Nursing Annual Update thereafter.

The table below summarizes MSH's compliance data for new nursing employees and existing nursing employees respectively (N) and completion of competency-based training in alignment with this requirement.</td>
</tr>
</table>

No. of Nursing Staff Who Completed Competency-Based Training on Nursing Orientation

	Mar	Apr	May	Jun	Jul	Mean
N = total number of new nursing staff	2	2	6	2	5	
n = actual number of new nursing staff who completed competency-based Nursing Orientation training/class	2	2	6	2	5	3
%S	100	100	100	100	100	
%C	100	100	100	100	100	100

Nursing Annual Update Compliance Report (*Training Category 1)

	Mar	Apr	May	June	July
N = total number of level of care nursing staff	719	719	719	719	719
n = number of level of care nursing staff trained and competent	719	719	719	719	719
%S	100	100	100	100	100
%C	80	80	79	78	76

* Training Category 1 - level of care nursing staff

Compliance:
Partial.

Current recommendation:
Continue monitoring this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Rebecca McClary, Chief of Rehabilitation Services 2. Kenneth Layman, Treatment Enhancement Coordinator 3. Keisha Foster, Speech Therapist 4. Julia Hastings, Physical Therapist 5. Joanna Cooper, Speech Therapist 6. Asha Vij, Occupational Therapist 7. Adella Davis-Sterling, Supervising Registered Nurse 8. Julie Duane, PNMP Team leader 9. Marion Palcibar, Physical Therapist 10. Willie Smith, Recreation Therapist 11. Wanda Wullschleger, Recreation Therapist 12. Conducted meeting with Unit Supervisors and Program Directors to get feedback on Rehabilitation Services team participation and systems issues. Reviewed: 1. List of individuals receiving direct Occupational Therapy services 2. Records, therapy documentation and corresponding WRPs for the following individuals in direct Occupational Therapy: RW, JA, TP 3. List of individuals receiving direct Physical Therapy services 4. Records, therapy documentation and corresponding WRPs for the following individuals in direct Physical Therapy: JM, TP, EN 5. List of individuals receiving direct Speech Therapy services 6. Records, therapy documentation and corresponding WRPs for the following individuals in direct Speech Therapy: RW, MM, JA 7. Audit data for Rehabilitation Therapy Referrals for March-June 2007 8. MSH findings and corresponding documentation for informal audit of WRP documents for sample of individuals in the

		Communication/Speech group for the following individuals: LB, JC, MD, JL, EL 9. The Physical, Occupational, and Speech Therapy procedure (AD No. 1052) 10. MSH Dining Plan Audit Tool 11. MSH Adaptive Equipment Audit Tool 12. Quarterly Qualitative Profile for Rehab Assessment for 2007 13. Group Facilitator Monitoring data for March-July 2007 14. List of individuals with Dining Plans 15. List of individuals with adaptive equipment/Adaptive Equipment database 16. Mealtime Competency-based Training Checklist 17. Positioning Competency-based Training Checklist 18. Communication/Speech group Roster dated 8/14/07 19. MSH Wheelchair Cleaning/Maintenance Policy Draft 20. MSH Wheelchair Cleaning Tracking Log 21. MSH Wheelchair Tracking Log for July-August 2007 22. Active Treatment hours per therapist (scheduled vs. completed) for the past month 23. 12 week Lesson Plan for Strategies and Techniques for Substance Abuse Education and Prevention 24. 12 week Lesson Plan for Leisure Awareness 25. 12 week Lesson Plan for Sing Along 26. 12 week Lesson Plan for Recreation Therapy Group 27. Weight Lifting Course Description and 24 week Lesson Plan 28. 12 week Lesson Plan for Physical Exercise 29. 12 week Lesson Plan for Horticulture 30. 12 week lesson plan for Negative Thinking 31. 12 week lesson plan for Recreation Therapy <u>Observed</u>: 1. PE group on Program 3 unit 2. Horticulture Group on Program 1

		3. Recreation Therapy Group on Program unit 418 4. Music Movement Group on Program 3 unit 401 5. Individuals during Physical Therapy treatment: JA, RW 6. Individual during Occupational Therapy treatment: JA 7. The following individuals at mealtime: GF, GD, LP, JA, DE
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to integrate OT, PT, and Speech Therapy into the Rehabilitation Department and the WRPT process. **Findings:** There is not currently a procedure that specifies when an Occupational, Physical, or Speech Therapist should attend WRPCs. There is no protocol/format in place by which Occupational, Physical, and Speech Therapists can report recommended supports (e.g., groups, communication devices, adaptive equipment, Dining Plans) and individualized functional objectives to the WRP, and report monthly progress towards these objectives, or changes in direct services (e.g., discharge, change in frequency). Completion of a monthly summary by OT, PT, and SLP with report to the WRPT is required as stated in AD 1052, but the process by which this occurs is not specified in current procedure, and therapists interviewed report that they have not been trained on this procedure. There are no policies in place that ensure consistency, quality, and

		timeliness of treatment plans and documentation of progress for individuals receiving direct (1:1) Occupational, Physical, and Speech Therapy. According to AD 1052, Physical, Occupational, and Speech Therapy procedure, therapists are required to document progress on MSH form 1167, yet this is not currently being done. Upon interview of therapists and review of documentation, it was noted that therapists complete either daily, weekly or monthly progress notes, yet this is not consistent in practice between therapists. No monitoring or audit currently exists to examine whether Physical, Occupational, Speech, Psychosocial Rehabilitation therapists, or Industrial Therapists/Vocational Rehabilitation staff recommendations and objectives are implemented and appropriate, to ensure WRP participation via attendance and/or monthly summaries, and to ensure appropriate and meaningful direct treatment. Currently, there is not a procedure in place to determine when an individual requires a Dining Plan, nor is there a consistent format by which a Dining Plan is developed, and implemented with competency-based training as needed. Though a Dining Plan Audit tool exists that assesses for documentation compliance, there is no monitoring system/protocol in place to ensure that Dining Plans are appropriate, implemented, and incorporated into the individual's WRP. The Dining Plan audit tool should follow the flow of the Dining Plan itself, and ensure clinical insight regarding quality of implementation. Upon interview with the Physical Nutritional Support Team it is noted that individuals with adaptive equipment are monitored daily by the individual's Nurse, even when individual is independent with her/his adaptive device. There is no procedure in place by which the therapist recommending the equipment monitors to ensure re-assessment, implementation, and effectiveness of adaptive equipment as needed, nor is there a procedure in place to determine when competency-based

		training is needed for adaptive equipment implementation. **Current recommendations:** 1. Develop and implement a procedure to specify WRPC attendance requirements per discipline, according to individualized needs (e.g., receiving direct treatment). 2. Develop and implement a procedure that specifies criteria for the need for and implementation of a 24-hour support plan related to physical and/or nutritional support. 3. Revise and current Dining Plan (focused on dysphagia management) so that it is able to address any nutritional, physical, and/or communication support needs, with focus on support and function in addition to management of risk and implement 24-hour Physical/Nutritional Support Plan. 4. Revise and implement the Physical, Occupational, and Speech Therapy procedure (AD 1052) to encompass all direct 1:1 Rehabilitation Therapy Services, and include descriptions of format and means by which to report findings to the WRPT for all Rehabilitation Therapy documentation of progress regarding direct treatment in Vocational Rehabilitation, Physical Therapy, Speech Therapy, Occupational Therapy and Psychosocial Rehabilitation Therapy. 5. Provide competency-based training to Rehabilitation Therapy staff regarding Recommendation #4. 6. Ensure that all Rehabilitation Therapy staff is provided competency-based training on documentation of progress towards individual objectives using the Mall Facilitator Monthly Progress note. 7. Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment and indirect supports (e.g., Dining Plan, adaptive equipment), corresponding documentation of supports and progress, and incorporation of objectives and recommendations into

		the WRP. 8. Establish inter-rater reliability among staff performing audit prior to implementation of this audit tool.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs. **Findings:** No protocol for this process has been developed or implemented at this time. **Recommendation 2, March 2007:** Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring. **Findings:** The facility has put together a training book to record all competency-based training performed by Physical, Occupational, and Speech therapists. However, no monitoring system has been developed or implemented at this time. **Current recommendation**: Develop and implement a plan to ensure in vivo monitoring of Physical Therapy programs occurs as needed.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment,	**Current findings on previous recommendations:**

	transferring, and positioning, as well as the need to promote individuals' independence.	**Recommendation 1, March 2007:** Develop and implement a system to provide and document competency-based training on this requirement. **Findings:** Upon interview with Physical Nutritional Support Team, it is noted that the current informal procedure is to provide competency-based training to Nursing staff for all individuals with adaptive equipment. There is not a procedure in place that prompts clinicians to determine when competency-based training is necessary. For example, if an individual is independent with adaptive device, competency-based training to staff is not necessary. In addition, the individual her/himself may require competency-based training to ensure implementation of the device, rather than training to the staff. According to the Professional Education Staff Training Manual maintained by Physical, Occupational, and Speech therapy, evidence of competency-based training assessments were provided for RNs trained on Positioning and Adaptive Mealtime Equipment, though no lists of individuals trained were provided. The manual also included evidence of 10 Mealtime competency-based training assessments for staff on unit 415, one Mealtime competency-based training assessment for individual GD, and Oral/Medication administration competency-based training assessment for two staff. **Recommendation 2, March 2007:** Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement. **Findings:** This system has not been developed at this time.

		Compliance: Partial. **Current recommendations**: 1. Continue to provide competency-based training for individualized Physical/Nutritional support plans that require return demonstration or test as needed to determine competence. 2. Develop and implement a plan to ensure that in vivo monitoring of supports occurs as needed on an individualized basis as determined by specified criteria to ensure compliance with implementation and continued appropriateness of supports.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Develop and implement a system to adequately monitor this requirement. **Findings:** As stated in F.4.a., there is no procedure in place to monitor for Rehabilitation Therapy service implementation. The Qualitative Rehabilitation Therapy monitoring tool examines implementation of psychosocial Rehabilitation Therapy services including monthly progress note completion, and group start and end times. According to MSH audit data for March-July 2007, monthly progress notes were completed in 29% of records reviewed. **Other findings:** According to review of WRPC attendance sheets for individuals in direct Occupational, Physical, and Speech therapy programs, or individuals receiving recommendations from assessment referrals, average attendance for each discipline was as follows: Occupational

		Therapy- 0%; Speech Therapy- 0%; and Physical Therapy- 9%. Completion of a monthly summary by OT, PT, and SLP with report to the WRP is required as stated in AD 1052. However, upon review of treatment documentation for Occupational, Physical, and Speech therapists and interview with therapists, it was noted that 0% had completed monthly summary with report to the WRPT. Upon observation of WRPC for JA, it was noted that objectives and progress in direct Occupational, Physical, and Speech Therapy were not reported to the team, and no therapists were present at the meeting. Upon review of sample of WRPs of individuals who participated in mall groups facilitated by Psychosocial Rehabilitation Therapists, 78% attendance by Rehabilitation Therapist was noted. However, during meeting with Program Directors and Unit Supervisors, it was reported that overall attendance at WRPCs by psychosocial Rehabilitation therapists is consistent, and that RT participation in the WRP process is not a problem at this time. Upon review of treatment documentation and corresponding WRPs for direct Physical Therapy treatment, it was noted that 100% of records contained progress notes, 0% of WRPs contained progress note objectives/progress; 17% had functional objectives; 100% had measurable objectives; and 100% listed treatment activities that addressed objectives. One individual observed in Physical Therapy treatment (JA) had not had an evaluation performed and therefore had no treatment plan and objectives. Upon review of treatment documentation and corresponding WRPs for direct Speech Therapy treatment, it was noted that 100% of therapy charts contained progress notes, 0% of WRPs contained progress note objectives/progress; 0% had functional and measurable objectives; and 67% listed treatment activities that addressed objectives.

		Upon review of treatment documentation and corresponding WRPs for direct Occupational Therapy treatment, it was noted that 100% of charts contained progress notes, 0% of WRPs contained progress note objectives/progress; 83% had functional objectives; 100% had measurable objectives; and 100% listed treatment activities that addressed objectives. Upon interview with Assistant Chief of Central Program Services, it was noted that only 14% of individuals at MSH are currently employed, and that Vocational Rehabilitation lacks staff to perform Vocational and Industrial Rehabilitation Services. Upon review of informal audit data of Vocational Assessments and corresponding WRP's, it was noted that 0% had complete documentation of Vocational recommendations, objectives and progress. During observation of Mall Groups, it was noted that 75% of groups had individuals who were engaged and participating in activities. Overall, Rehabilitation Therapists observed were enthusiastic, and had good rapport with individuals. Of the curriculums written by RT reviewed for groups requested and observed, 67% had 12-week curriculums per WRP manual specifications. However, these curriculums were too general and lacked detail. Of the groups observed facilitated by RT, 0% had lesson plans, and 100% had treatment rosters. Upon review of WRPs for individuals observed in RT-led Mall groups, it was noted that 0% of WRPs contained functional, meaningful and measurable outcomes related to group participation, and 38% of WRPs listed the group that the individual was attending when observed. Upon review of the Monitoring for Dysphagia/Physical Nutrition Management Program database, it was noted that only 28% of individuals who require Dining Plans have had these plans completed and

		implemented, and 28% of individuals requiring plans have had training to staff regarding these plans by at least one member of the PNMP team. This monitor attempted to monitor Dining Plan implementation by observing meals at 420, 419, and 415. However, many of the Dining Plans were not written from assessment findings, but were written by a Nurse on unit, and were inconsistent in format. Many individuals with Dining Plans did not appear to need plans for safety and independence, as they were independent with diet modifications and/or adaptations. This monitor could not collect meaningful data related to Dining Plan implementation based on current system. According to the Discipline Summary of Facilitator Hours database for the week of June 4-9 2007, the averages for number of hours of active treatment scheduled (per protocol) versus number of hours of active treatment provided are as follows (by discipline): Recreational Therapy-72%; Music Therapy-73%; Art Therapy-75%; and Dance/Movement Therapy-78%. The database provided several therapists without titles, and thus these professionals' compliance percentages were not calculated in the above totals. The facility reports an overall average of 68% compliance with provision of active treatment hours for all Rehabilitation Therapists. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRP meetings as indicated per revised procedure. 2. Ensure that audit tool recommended in F.4.a.i. monitors for WRP inclusion of recommendations/objectives made by Rehabilitation Therapy as well as progress towards objectives. 3. Ensure that all Rehabilitation Therapists have received

		competency-based training on Psychosocial Mall Manual contents regarding the development of curricula, lesson plans, and course outlines, as well as WRP process and Enhancement Plan requirements.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Develop and implement a system to adequately monitor this requirement. **Findings:** According to facility report, currently all adaptive equipment is monitored on daily logs by Nursing staff. There is no procedure/system in place to ensure that monitoring occurs as needed on an individualized basis, by appropriate clinicians (e.g., clinician who recommended the equipment). The Adaptive Equipment Audit tool was reviewed and is brief, consisting of two yes/no checkboxes and a comments section. Review of the Adaptive Equipment Log reveals that 49 individuals currently require the use of adaptive equipment, though based on current format there is no indication of how many of these individuals have had equipment implemented in a timely manner, or have had reviews to ensure implementation and appropriateness/effectiveness of equipment. Adaptive Equipment Tracking Log is difficult to interpret and appears to conflict with Adaptive Equipment Log. According to facility database for individuals with wheelchair/mobility needs, 32% of individuals assessed have had wheelchairs/mobility devices implemented.

		Compliance: Partial. **Current recommendations**: 1. Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with clinical expertise to determine compliance with both implementation and continued appropriateness of supports. 2. Revise and implement current adaptive equipment log to track when a piece of equipment is ordered, as well as the date of training/implementation of the equipment.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Mary Christina Marshall, Director of Dietetics 2. Ninfa Guzman, Hospital Administration Resident 3. Portia Salvacion, Assistant Director of Dietetics Reviewed: 1. Memorandum for Plan of Correction for Axis III Focus 6 Medical Nutrition Problems dated 7/9/07 2. Study C (Non Opened/Addressed Axis III Focus 6) Data Summary 3. WRP documents for the following individuals reviewed for Plan of Correction Study C: JN, JU, ES, LP, LL, JP 4. Medical Conditions Focus 6 Monitoring Tool 5. Medical Conditions Monitoring Form Instructions 6. Meal Accuracy Report Draft (8/3/07) 7. Statewide Clinical Nutrition Weight Management Protocol Draft (7/07) 8. New Employee Orientation Training module for Weight Management 9. MSH AD 3413 Clinical Nutrition Weight Management Protocol (approved 3/07) 10. Production Performance Improvement Report 2nd Quarter 2007 11. Solutions for Wellness Training Curriculum, post-test, and corresponding sign in sheets 12. Statewide Dietetics Wellness and Recovery Plan Training Policy Draft 13. Nutrition Care Monitoring Tool Instructions (revised) 14. Nutrition Assessment and Incorporation into the WRP Pre-Post Test 15. Nutrition Assessment and Incorporation into the WRP sign in sheets 16. Nurses Role in the Nutrition Care Process Pre-Post Test

		17. Nurses Role in the Nutrition Care Process sign in sheets 18. Nutrition Management of Diabetes Mellitus/Weight-Health Issues Outline 19. Nutrition Management of Diabetes Mellitus/Weight-Health Issues Post Test 20. Nutrition Management of Diabetes Mellitus/Weight-Health Issues sign in sheets 21. MSH AD 3414 Physical and Nutritional Management (implemented and approved 3/07) 22. Statewide Draft 071907 for Dysphagia and Aspiration Management 23. Physical Nutritional Support Timeline 24. Physical and Nutritional Support Training Outline 25. Comprehensive Team Assessment for Physical and Nutritional Management Pilot Draft 26. Records for the following individuals with Nutrition Care Assessments (random sample from all Nutrition Assessment Types) to assess for Nutrition Care Training and response: NH, NP, MC, LS, TS, CL, SW, JM, JAM, GK, SC 27. Curriculums for Weight Management, Nutrition Education, and Weight Management Proposed Behavior Modification Strategies
F.5.a	Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and initiate plans of correction for those individuals who have not had the appropriate Axis III, Focus 6 initiated. **Findings:** According to facility report and confirmed by review of corresponding documentation, an Axis III Focus 6 study was performed and the findings were as follows: 1. 28 individuals had a BMI of 40 or greater, of which 23 had the

		problem addressed in the WRP, and five had not been addressed in the study presented in the last CM progress report. Of those identified but not addressed in the WRP, all five have been addressed. 2. There were six individuals (JN, JV, ES, LP, LL, and JP) with nutrition-related medical problems that were not initiated/addressed by the WRP in the last CM progress report; five have been addressed, and one remains not opened or addressed in the WRP (J. P. Unit 411). This individual is receiving care and recommendations for obesity through diet (2000 cal ADA, No Added Salt) and exercise (participates in walking group and Health Awareness). 3. Axis III Focus 6 medical problems are monitored by nursing via "(l) Medical Conditions Monitor: Section III Integrated Therapeutic and Rehabilitation Services Planning Monitoring Tool F7(c) Medical Conditions Focus 6 Monitoring Tool (for C2.1 and F7. of the Enhancement Plan). Nutrition Related issues will be identified through this process. **Recommendation 2, March 2007:** Implement monitoring instrument for this requirement when approved. **Findings:** The DMH Nutrition Task force has developed a Meal Accuracy Report draft to monitor for implementation of in vivo nutritional supports/ recommendations. The tool will monitor a 20% sample size of Regular and Modified Meals for meal accuracy. **Recommendation 3, March 2007:** Continue to monitor the elements of this requirement. **Findings:** According to record review, 89% of Nutrition Care Assessments had

		evidence of Nutrition Training/Education and documentation of individual response. Nutrition Education/Training is a direct service provided by Dietitians to individuals and is based on objective assessment findings. According to facility report, trays audited from April-July by Food Supervisor I's and Supervising Cook I's were 93% accurate. Curriculums for Weight Management, Nutrition Education, and Weight Management Proposed Behavior Modification Strategies were reviewed and found to be presented in a 12-week format, with objectives, section description, teaching method/tools, and outline listed for each lesion/session. This appears to be consistent with the requirements of the Psychosocial Mall Manual. Facilitator hours by Dietitian were not provided to this monitor, but will be requested next review. **Compliance:** Partial. **Current recommendations:** 1. Implement Meal Accuracy Report procedure to monitor for implementation of in vivo nutritional supports/recommendations. 2. Continue current practice.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Restructure data to clarify what information is being presented in alignment with the EP. **Findings:** Data to determine compliance for this requirement will be related to the role of the Dietitian in the WRP process in ensuring implementation

		of nutrition care recommendations by inclusion into the WRP. This includes education of Nursing staff regarding Nutrition Care issues for report to the WRP, as well as monitoring of WRP to ensure Nutrition Care recommendation integration. **Recommendation 2, March 2007:** Continue to monitor the elements of this requirement. **Findings:** The DMH Task Force has developed a draft procedure for this cell, which was confirmed by review. Nutrition Services continues to provide "Diabetes and Nutrition Related Concerns" training during Nursing Orientation Training and Annual Nursing Update training. The DMH task force currently conducts training with adapted post-tests for all new nurses regarding "The Role of the R.N. representing the R.D. in the WRP". In addition, the current Nutrition Care Monitoring Tool and instructions have been revised to include a section to monitor whether the WRP addresses the recommendations of the Registered Dietitian. Upon record review of all Nutrition Care assessments listed in D.5, it was noted that 87% of corresponding WRP documents contained Nutrition Care objectives/diagnosis/recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or	**Current findings on previous recommendations:**

	dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Recommendation 1, March 2007:** Restructure data to clarify what information is being presented in alignment with the EP. **Findings:** AD 3414 procedure for dysphagia was implemented in March 2007. No specific data is required to determine compliance for this section of the Enhancement Plan specific to Nutrition Services. Compliance will be determined based on the role of the Dietitian in contributing to and complying with facility-wide dysphagia policy. **Recommendations 2 and 3, March 2007:** 2. Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia. 3. Continue to develop and implement 24-hour, individualized dysphagia care plans. **Findings:** Assessment of swallowing, dysphagia risk, aspiration risk, and mealtime interventions/24 hour supports do not fall within the scope of practice for Registered Dietitians. The role of the Dietitian as a team member in serving individuals at risk for dysphagia and aspiration is well established within current procedures related to dysphagia. **Recommendations 4 and 5, March 2007:** 4. Continue to provide competency-based training to staff regarding risk of aspiration/dysphagia. 5. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/ dysphagia.

		Findings: Competency-based training has been initiated by Nursing and OT/PT/SLP; this type of training does not fall within the scope of practice for Clinical Dietitians. **Recommendation 6, March 2007:** Continue to develop and implement a monitoring system for this requirement. **Findings:** A monitoring system for this requirement (monitoring of Dining Plans) has not been developed and implemented. See F.4 for additional findings. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Restructure data to clarify what information is being presented in alignment with the EP. **Findings:** Data regarding Dietitian competency-based training related to aspiration and dysphagia will be used to determine compliance with this section of the Enhancement Plan. **Recommendations 2 and 3, March 2007:** 2. Continue to ensure staff competency-based training regarding the

		implementation of this requirement. 3. Continue to develop and implement a monitoring system regarding this requirement. **Findings:** According to facility report, 78% of dietitians have currently received Comprehensive Training in Dysphagia Management and PNMP team role, and 22% of Dietitians have received training on 24-hour plans. Signature sheets were provided but competency-based scores were not listed or provided to this monitor. Currently, the Director of Dietetics has been responsible for tracking and monitoring the provision of competency training for all staff hospital-wide. However, this is not an efficient use of her administrative time and clinical expertise related to the Dietitian scope of practice. **Compliance:** Partial. **Current recommendations**: 1. Discontinue tracking of dysphagia training by Director of Dietetics for all MSH staff, and focus on tracking whether dysphagia-related competency-based training for Dietitians has occurred. 2. Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Restructure data to clarify what information is being presented in alignment with the EP.

		Findings: No specific data is required to determine compliance for this section of the Enhancement Plan specific to Nutrition Services. Compliance will be determined based on the role of the Dietitian in the WRP team process. **Recommendation 2, March 2007:** Continue to develop and implement a monitoring system regarding this requirement. **Findings:** Assessment of P.O. status does not fall within the scope of practice for Clinical Dietitians, but should be addressed by the WRPT with determination based on findings from Occupational therapy, Speech therapy, Physician, and Nurse assessments as well as objective diagnostic test findings. **Compliance:** Substantial. **Current recommendation**: Collaborate with relevant disciplines (e.g., OT, PT, SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO status.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Glen Itow, PharmD, Director of Pharmacy 2. Harold Plon, PharmD Assistant Director of Pharmacy 3. Q. Nina, PharmD, Assistant Director Reviewed: 1. Memorandum from Medical Director (August 24, 2007) regarding the physicians' responsibilities in reviewing pharmacists' recommendations 2. MSH Pharmacy Policy and Procedure Manual, subject: Medication Orders (effective February 8, 2007) 3. Summary of MSH monitoring data
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to provide the needed IT support in collaboration with the pharmacy department. **Findings:** The facility did not provide specifics regarding the implementation of this recommendation. **Recommendation 2, March 2007:** Continue to monitor the elements of this requirement. **Findings:** The facility has implemented this recommendation (April to July 2007). The total target population (number of new medications prescribed) was significantly increased in April with the introduction of a new

		software system that improved the calculations. Reviewing an average sample of 21%, the facility reported a mean compliance rate of 100% regarding the pharmacist providing recommendations that address drug-drug interactions, potential side effects and laboratory screening required. The pharmacy leadership indicated that current staffing shortage is such that further monitoring efforts may be very difficult to sustain. **Compliance:** Partial **Current recommendations:** 1. Continue to provide the needed IT support in collaboration with the pharmacy department and provide a specific outline of the implementation. 2. Continue to monitor this requirement. 3. Address and correct factors related to shortages of pharmacy staff.
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement a policy addressing the responsibility and required actions by the medical staff regarding pharmacy recommendations. **Findings:** MSH Pharmacy Policy and Procedure Manual, subject: Medication Orders (effective February 8, 2007) addresses this recommendation. **Recommendation 2, March 2007:** Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified.

		Findings: The facility has yet to develop a medical staff procedure addressing physicians' responsibilities and actions in this regard. **Recommendation 3, March 2007:** Continue to monitor this requirement. **Findings:** The above-mentioned monitoring process was used to assess compliance with this requirement. During the period of April to July 2007, the facility reported 100% compliance with this recommendation. The facility recognizes possible sample bias because monitoring was performed exclusively for new medication orders and did not include all current orders. **Compliance:** Partial. **Current recommendations:** 1. Develop a medical staff procedure addressing physicians' responsibilities and actions regarding pharmacists' recommendations. 2. Continue to monitor this requirement.

7. General Medical Services		
		Methodology: Interviewed: 1. Thai Vu, MD, Staff Physician and Surgeon 2. Tuyen Le, MD, Staff Physician and Surgeon 3. Leonard Liu, MD, Staff Physician and Surgeon 4. Bhaviesh Shah, MD, Staff Physician and Surgeon 5. Bashir Shaw, MD, Staff Physician and Surgeon 6. Chi Vu, MD, Staff Physician and Surgeon 7. Quynh Pham, DO, Staff Physician and Surgeon Reviewed: 1. List of all individuals transferred to a general medical facility since January 1, 2007 2. Admission Assessment Monitoring Form 3. Admission Assessment Monitoring summary data (March to July 2007) 4. Ongoing Medical Care Monitoring Form 5. Ongoing Medical Care Monitoring summary data (March to July 2007) 6. Non-Emergent Medical Care Monitor 7. Non-Emergent Medical Care Monitoring summary data (May to July 2007) 8. Medical Emergency Response Monitoring Form 9. Medical Emergency Response Monitoring summary data (March to July 2007) 10. Metabolic Disease Monitoring Form 11. Metabolic Disease Monitoring summary data (April to July 2007) 12. Quality of Care (Asthma/COPD) Monitoring Form 13. Quality of Care (Asthma/COPD) Monitoring summary data (May to July 2007) 14. X-ray, EKG and Critical Laboratory Testing Monitoring summary

		data (March to July 2007) 15. Outside Appointments and Hospitalizations Monitoring Form 16. Outside Appointments and Hospitalizations Monitoring summary data (March to July 2007) 17. Medical Conditions Focus 6 Monitoring Form 18. Medical Conditions Focus 6 Monitoring summary data (May to July 2007) 19. Memorandum from Medical Director (May 25, 2007) regarding attendance of Medical Consultants at WRPCs 20. Revised Medical Care Policy and Procedure (effective July 9, 2007) 21. Medical Emergency Response Worksheet 22. Medical Emergency Drill Report 23. Schedule regarding coverage by the on-call physician 24. MSH data regarding Antibiotic Susceptibility Testing (Trends and Patterns)
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that the medical policy and procedure adequately address all of the requirements outlined in the findings under Recommendation 1, September 2006. **Findings:** MSH revised its Medical Care Policy and Procedure (July 9, 2007) to address the ten areas listed in the previous report. The following is a summary of the changes made in reference to each area: 1. **Requirements regarding completeness of all sections of initial assessments**: The revised policy includes a statement (page 3) that no part of the physical examination may be deferred if the individual has not refused the examination.

		2. **Timeliness and documentation requirements regarding medical attention to changes in the status of individuals**: The revised policy (page 6) includes mechanisms to ensure that the nurse: a) notifies the physician when a change in the individual's condition has been identified; b) documents (in the progress notes section of the chart) the time the physician was (or will be) notified of the condition; and c) documents the time the individual leaves the hospital grounds. However, the requirements regarding documentation by nursing do not specify that the documentation must occur upon notification of the physician, and that the physician's name must be included. In addition, the revised policy does not include requirements regarding documentation by physicians of their assessments of the changes in individuals' medical conditions. 3. **Requirements for the preventive health screening of individuals**: The revised policy includes these requirements upon admission (page 3) and annually (page 5). 4. **Proper physician-nurse communications**: The revised policy (page 4) documents the timeframes for physicians' responses to notification by nursing depending on the urgency of the change in the individual's condition. The timeframes are: 15 minutes (emergent condition), two hours (urgent condition) and 24 hours (non-urgent condition). Given the operational realities at MSH, these timeframes are adequate. However, the revisions made by MSH do not include adequate terminology in the definitions of routine, urgent and emergent conditions 5. **Emergency medical response system, including drill practice**: The revised policy addresses some elements of the medical emergency response (page 6). The facility also has a separate procedure regarding the Emergency Medical Response System. However, the

		procedure regarding the medical emergency response system is not aligned with the Medical Care policy regarding the timeliness of the evaluation of the individual. In addition, the documents presented by the facility do not include a medical emergency response drill evaluation sheet or any adequate mechanism to assess the performance of staff during emergency drills and indicate how these processes can be utilized for corrective actions/performance improvement. 6. **Communication of needed data to consultants;** 7. **Timely review and filing of consultations and laboratory reports; and** 8. **Follow-up on consultants' recommendations**: The revised policy (pages 4 and 5) includes statements regarding: a) the referral process to on/off site clinics; b) review by physicians of the results of consultations and laboratory testing; c) documentation by physicians of follow-up regarding consultation results. However, this procedure does not specify the mechanisms required for obtaining (and filing results of) medical diagnostic testing, including laboratory services, electrocardiogram (EKG), radiology/nuclear medicine services and electroencephalogram (EEG) as well as monitoring of medical diagnostic testing and consultations and documentation to indicate appropriate follow-up by the medical staff regarding abnormal results of medical diagnostic testing. 9. **Assessment of medical risk factors that are relevant to the individual in a manner that facilitates and integrates inter-disciplinary interventions needed to reduce the risk**: The revised policy (pages 5 and 6) includes a requirement for physicians to document a medical progress note every two months that addresses medical risks (as applicable) and that outlines factors contributing

		to the risk. This procedure does not provide guidance on the issue of interdisciplinary interventions required to reduce the risk. 10. **Parameters for physicians' participation in the WRP process to improve integration of medical and mental health care**: The revised policy (page 4) includes a requirement for the medical consultants to attend the WRPCs, as requested by the treating psychiatrist, to assist in the development of objectives and interventions. This statement is sufficient. In general, the facility's medical policy and procedure addressed most of the areas outlined by this monitor. However, the policy and procedure does not clearly separate purposes/policy statements from operational procedures, is written in a disorganized manner and overlaps with other procedures, which can confuse the practitioner. In addition, the policy contains too many ambiguities and linguistic errors, and does not provide the level of clarity that is required in any medical procedure. The facility's efforts in this regard indicate a need to organize the required information within three main documents (see current recommendations below). **Recommendation 2, March 2007:** Implement the revised medical policy and procedure. **Findings:** MSH has yet to implement this recommendation. **Recommendation 3, March 2007:** Continue to monitor this requirement and ensure at least a 20% sample. **Recommendation 4, March 2007:** Consolidate the monitoring instruments, utilizing indicators that are aligned with the policy and procedure, address preventive, routine,

		specialized and emergency care and are integrated with the peer review system. **Findings:** MSH used the following monitoring processes to assess compliance with EP requirements regarding medical services. These processes adequately address the above recommendations: 1. **Admission Assessment Monitoring Form**: As mentioned in D.1.c.i, MSH used this form to assess compliance with the requirements regarding timeliness and completeness of the initial physical examination. The data are outlined in D.1.c.i. In addition, the facility added an indicator to address the refusal/deferral of rectal examinations. MSH reviewed an average sample of 90% (March to July 2007) of all new admissions per reporting month. The facility reported compliance rates of 100% with all the indicators. 2. **Ongoing Medical Care Monitoring**: The facility reviewed an average sample of 43% of the total number of individuals who have chronic diseases, e.g. Diabetes, asthma, hypertension or other medical problems and were seen at the clinics (March to July 2007). The following is an outline of the monitoring indicators and corresponding mean compliance rates: a. *Was an appropriate medical (acute/chronic) conditions and treatment been addressed and documented?* 99% b. *If applicable, was an appropriate medical work up (lab, X-ray, consultation etc…) done?* 97% c. *I yes on # 2, has the physician reviewed and followed up on the test results and/or the recommendations of the consultants?* 96% d. *If the individual's condition is required to be managed by the*

		outside facility, has the individual been transferred for continuing care in a timely manner and documented in the chart? 100% e. *Was medical care adequate and appropriate as recommended by the medical society/hospital policy?* 95% f. *Has the annual physical exam been completed in a timely manner?* 65% g. *Have all the chronic medical conditions been addressed and integrated into the WRP? 94%* The facility's data show low compliance with the performance of pap smears and the reoffering of rectal examinations and pap smears to individuals who have refused the tests. However, the monthly data show relative recent improvement in these two categories 3. **Non-emergent medical care monitoring monthly**: MSH reviewed an average sample of 41% of the total number of individuals who had significant medical problems (e.g. fever and cough to rule out pneumonia, fall with ankle injury to rule out bone fracture, head trauma, seizure, self-inflicted laceration, pica behavior, critical lab value etc.) which were reported daily by HSSs. The following outlines the mean compliance rates for each indicator (May to July 2007): a. *Was the patient seen in a timely fashion (within one hour for non-life-threatening emergencies)?* 96% b. *Was an appropriate history documented?* 97% c. *Was an appropriate physical examination performed and documented?* 97% d. *Was an appropriate differential diagnosis generated?* 93% e. *If there was tissue damage, was tetanus status ascertained?* 93%

		f. *If patient suffered a human bite or exposure to blood/body fluid, was HIV & hepatitis screening performed?* 100% g. *Were appropriate diagnostic steps (lab, x-ray, etc.) undertaken?* 98% h. *Was medical care adequate & appropriate?* 98% 4. **Medical Emergency Response Monitoring:** The Director of the Medical Service reviewed all episodes of medical emergency response (MER) that occurred during the period of March to July 2007. The facility reported 100% compliance with the following indicators: a. *EMS activated?* b. *Physician arrived within 15 minutes?* c. *HSS arrived within 15 minutes?* d. *Paramedics arrived within 15 minutes,* e. *Vital signs recorded?* f. *CPR initiated?* g. *AED applied?* h. *Oxygen initiated 2L/minute or more?* i. *Transfer to off-site hospital?* 5. **Metabolic disease monitoring**: MSH has refined and consolidated the monitoring instruments regarding the care of hypertension, diabetes, obesity and/or dyslipidemia. The facility reviewed an average sample of 53% of the individuals who have diabetes, hypertension, dyslipidemia and/or obesity and were seen at the clinic. The monitoring was conducted from April to July 2007. The following is an outline of most relevant indicators and corresponding mean compliance rates: a. *If diabetes present, has HgA1C quarterly ordered?* 94% b. *If HgA1c ordered, has HgbA1C < or =7%?* 86%

		c. *Is blood sugar (FBS, Glucoscan) currently monitored?* 99% d. *If hypertension present, is blood pressure < or = 130/80?* 94% e. *If dyslipidemia present, has it been treated?* 100% f. *Is HDL level > 45 (m) or > 55 (f)?* 32% g. *Is LDL level < or = 100?* 69% h. *Is triglyceride < or = 150?* 61% i. *If the individual has a BMI > or = 27 or waist circumference is > 40 (m) or 35 (f), has a special diet been ordered?* 100% j. *If the individual has a BMI > or = 27 or waist circumference is > 40 (m) or 35 (f), has a weight control program been initiated?* 99% k. *Has an ophthalmologist/optometrist completed an eye examination at least annually for the individual with a history of diabetes/hypertension?* 100% l. *Has foot care been given for the diabetic individual at least annually by a podiatrist?* 100% m. *Unless contraindicated (and if individual is age 40 or older) has aspirin been ordered for the diabetic/hypertensive individual?* 81% n. *Is diabetes, hypertension or dyslipidemia included on Focus 6?* 88% o. *Does the WRP reflect objectives and interventions for diabetes, hypertension, or dyslipidemia?* 87% MSH provides adequate analysis of how the results of this monitoring reflect the quality of medical care provided to these individuals. 6. **COPD/Asthma Monitoring:** MSH presented monitoring data based on a review of an average sample of 53% of the number of individuals with asthma or COPD and seen at the clinic (May to July 2007). The following is an outline of the indicators and corresponding mean compliance rates:

		a. *Baseline chest x-ray done?* 97% b. *Baseline peak flow rate checked and documented by asthma clinic?* 100% c. *If the individual requires PRN medication, was the medication given < 2 days per week?* 90% d. *If the individual requires PRN medication, has expiratory flow rate been checked before and 30 minutes after treatment?* 100% e. *Has asthma/COPD been included on Focus 6 in the WRP?* 83% f. *If the individual smokes, is a smoking cessation intervention discussed and included in the progress note?* 83% g. *If the individual has been here for more than a year, is there documentation of a yearly flu vaccination?* 96% 7. **X-ray/EKG/critical laboratory monitoring**: The facility presented monitoring data to assess systems for reporting of x-ray, EKG and Stat/critical laboratory results based on a review of a 100% sample. The following is a summary of compliance (March to July 2007): a. *Stat x-ray orders should be done within one hour:* 100% b. *Accuracy of x-ray interpretation by PMC:* 99% c. *Stat EKGs notified within 30 minutes:* 100% d. *Timely reporting of routine EKG within 48 hours:* 100% e. *Critical and Stat lab results reported to the unit within one hour after completion of the test:* 100% **Other findings:** This monitor reviewed the charts of 10 individuals who were transferred to outside medical facilities during this review period. The staff physicians and surgeons who were involved in their care were interviewed. The following table summarizes the circumstances of the

transfers:

Initials	Date/time of evaluation	Reason for transfer
AC	4/16/07 11:00	Seizure activity (new onset)
BY	4/19/07 14:15	Abdominal pain R/O impaction (small bowel perforation)
DW	4/30/07	Shortness of breath (pneumonia, pulmonary hypertension and COPD)
TDD	5/5/07 17:00	Abdominal obstruction
PW	7/1/07 10:20	Seizure activity (recurrent)
TP	7/2/07 10:00	Foreign body ingestion
CG	7/3/07 9:50	Lower lobe pneumonia (pleural effusion)
RM	7/4/07 11:40	Intestinal obstruction secondary to pica
JS	7/17/07 09:00	Vomiting, R/O SIADH
CR	7/17/07 14:30	Abdominal pain (FB ingestion)

The review showed that in general, the facility has maintained adequate and timely care to these individuals. However, there are a number of significant deficiencies that must be corrected in order to achieve substantial compliance with EP requirements. The following are case examples:

		1. RM: The physician was unable to state how he was notified of the change in the individual's condition or find documentation in the chart of the outcome of the hospital stay. 2. PW: The nurse's documentation of the timing of change in the individual's status (seizure activity) is discrepant with the physician's note. 3. AC: There is no documentation of possible etiology of new-onset seizure activity in an elderly individual. 4. JS: There is no documentation of attention to or follow-up regarding low serum sodium levels dating back to at least March 2006. This appears to have resulted in delayed detection of SIADH. 5. TDD: There is no documentation of the outcome of the hospital stay for workup of possible bowel obstruction. 6. CG: There is no documentation of medical follow-up (during a weekend) of the status of an individual with fever or of the workup/treatment provided at the general medical facility. These deficiencies indicate a need for corrective actions, including but not limited to the following: 1. Upon return transfer of an individual from a general medical facility, the admitting physician documents, in the admission note, the following information: a. Workup performed at the hospital, including significant clinical and diagnostic testing findings; b. Outcome of the hospital stay, including diagnosis and status of the individual; and c. Any changes in medical treatment as a result of the hospital stay. 2. There must be communication between the admitting physician and the regular medical consultant regarding above. This communication should be documented prior to the individual's

		transfer to the care of the regular medical consultant. 3. If hospitalization occurred during the interval, written progress notes by the regular medical consultant (every two months at MSH) should include: a. Information regarding the workup at the hospital and outcome of hospital stay; b. Any changes in interventions, by medicine or other discipline, that are needed to reduce the risk for the individual; and c. An alert to the WRPT leader (psychiatrist) if a new or change in focus/ objective/intervention is needed as a result of the hospitalization. 4. Any inter-unit transfer assessment must include results of the hospital stay and changes in medical treatment/other interventions required to reduce the risk, if hospitalization occurred during stay on the unit. 5. There must be communication between the regular medical consultant and the on-call physician covering during off-hours, including weekends, regarding needed follow-up on a change in an individual's physical status that requires reassessment during the weekend/off hours. 6. There must be communication between the on-call physician and the regular medical consultant regarding any changes assessed by the on-call physician and interventions provided during the weekend/ off hours. **Compliance**: Partial. **Current recommendations:** 1. Revise the Medical Policies and Procedures to address and correct deficiencies outlined under Recommendation 1 above. The facility needs to organize the required information within three main documents. The following is a suggested outline of the scope of

		each document: a. Medical Attention to Individuals Policy and Procedure: This document should provide requirements for: 1) initial medical assessment of individuals upon admission and for regular reassessments during the hospital stay; 2) assessing changes in the physical status by nursing and medical staff, including physician-nurse communications; 3) transfer and return transfer of individuals for/from care at a general medical facility; 4) integration of medical and mental health care; and 5) monitoring the timeliness and quality of these services. b. Medical Emergency Response Policy and Procedure: This document should provide requirements regarding: 1) the organization, training, equipment and operations of a medical emergency response system for the immediate assessment and initial care of individuals pending transfer to a general medical facility; 2) medical emergency drills procedure, including frequency of drills, composition of the teams, adequate scenarios of simulated emergencies, drill evaluation sheets and a performance improvement system; and 3) monitoring the timeliness and quality of these services. c. Medical Diagnostic Testing and Consultations: This document should provide requirements for 1) obtaining medical diagnostic testing and consultation services; 2) providing appropriate follow-up regarding these services; and 3) monitoring the timeliness and quality of these services. 2. Implement the revised policies and procedures. 3. Monitor this requirement based on at least a 20% sample. 4. Address and correct deficiencies outlined by this monitor under Other Findings above.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.

F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, March 2007:**

		Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations:** Same as above.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue current practice. **Recommendation 2, March 2007:** DMH should ensure that individuals residing in all facilities receive the same level of psychiatric back-up support after hours. **Findings:** MSH has implemented a system to ensure after-hours coverage by both staff physicians and surgeons and staff psychiatrists. This system is adequate to meet this requirement of the EP. **Compliance:** Substantial. **Current recommendations:** Continue current practice.

F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** MSH has reviewed an average sample of 30% of the total number of outside consultations or hospitalizations. Using the Outside Appointments and Hospitalizations Monitoring Form (March to July 2007), the facility reported the following compliance data: 1. Did the patient return with forms MSH #1147 A & B? (100%). 2. Did the patient return with the hospital notes and recommendations for follow-up? (99%) 3. Did the patient return with a discharge summary? (100%). 4. Was there a follow-up appointment scheduled by the hospital? (66%). 5. Did the patient receive timely care? (100%). **Other findings:** This monitor's findings in F.7.a indicate lower compliance than that reported by the facility regarding the availability of adequate documentation by the outside hospitals. **Compliance:** Partial. **Current recommendations**: Same as in F.7.a.
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional	**Current findings on previous recommendations:**

	standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Recommendation 1, March 2007:** Continue to monitor this requirement and ensure a sample size of at least 20%. **Recommendation 2, March 2007:** Improve compliance with this requirement. **Findings:** In May 2007, MSH has refined its Medical Conditions Focus 6 Monitoring form. The modified indicators are appropriate to the integration of physical care into other aspects of the WRP. Reviewing an average sample size of 26% of the monthly census, the facility reported the following compliance data: 1. *Each of the open medical conditions listed on the medical conditions list are identified in the WRP under focus 6?* 45%. 2. *Does the WRP identify the general medical diagnosis?* (86%). 3. *Does the WRP identify the treatment to be employed for this condition?* 76%. 4. *Does the WRP identify the related symptom to be m monitored by nursing staff?* (50%). 5. *Does the WRP identify by what means staff will monitor these symptoms?* 56%. 6. *Does the WRP identify by what frequency staff will monitor these symptoms?* (35%). 7. *Staff to perform these interventions is identified by title?* 39%. 8. *The medical consultant was present during the WRP?* 12%. 9. *Each focus 6 has a corresponding objective and intervention?* (70%). In addition, the facility reported data (under items 9 and 10 of the current monitoring form) that appear to be duplicative of other items and unnecessary.

		Compliance: Partial. **Current recommendations**: 1. Continue to monitor this requirement and simplify current monitoring tool. 2. Address and corrected factors related to low compliance.
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Same as in F.7.a. **Findings:** Same as in F.7.a. **Recommendation 2, March 2007:** Continue to provide data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care. **Findings:** MSH has implemented this recommendation. **Recommendation 3, March 2007:** Identify trends and patterns based on clinical and process outcomes. **Recommendation 4, March 2007:** Provide corrective actions to address problematic trends and patterns. **Findings:** The facility reviewed trends and patterns of antibiotic resistance of

		certain infections of the skin (methicillin-resistant Staphylococcus) and urinary tract (E. Coli) during the period of 2001 to 2006. The review resulted in meaningful recommendations for corrective actions. **Recommendation 5, March 2007:** Expedite efforts to automate data systems to facilitate data collection and analysis. **Findings:** MSH has yet to implement this recommendation. **Compliance:** Partial. **Current recommendations:** 1. Same as in F.7.a. 2. Continue to provide data on the medical triggers identified in the Key Indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care. 3. Continue to identify trends and patterns based on clinical and process outcomes. 4. Provide corrective actions to address problematic trends and patterns. 5. Expedite efforts to automate data systems to facilitate data collection and analysis.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Dr. M. Barsom, Acting Medical Director 2. Aurora Hendricks, CNS 3. Charlene Hooper, PHN 4. Loraine Clinton, PHN Reviewed: 1. AD 3403, Infection Control Program; AD 3120, AIDS-Prevention & Management; AD 3403.1, Disease Reporting, 2. Inter-Rater Reliability data 3. MSH protocols for Hepatitis A, B, and C 4. MSH's progress report and data 5. MSH IC MRSA Auditing Form 6. MSH IC Immunization Refusal Auditing Form 7. MSH IC Immunization Auditing Form 8. MSH IC Hepatitis C Auditing Form 9. MSH IC Annual PPD Auditing Form 10. MSH IC Admission PPD Auditing Form 11. MSH IC Refused PPD Auditing Form 12. MSH IC Positive PPD Auditing Form 13. MSH IC HIV Positive Auditing Form 14. MSH STD Auditing Form 15. Medical records for the following 32 individuals: RF, MP, CA, DS, RP, JK, MA, NJ, LW, LM, GS, TM, CL, CW, NM, AW, MC, LW, JM, CK, CJ, JB, JP, RO, TC, JJ, LO, IC, RF, CA, DS, OV
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.

F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current recommendations**: Assist the Infection Control Departments in all four facilities in developing and implementing a uniform monitoring system in alignment with the requirements of the EP. **Recommendation #1:** Develop and implement a monitoring system for the elements of these requirements. **Findings:** MSH has revised AD 3403, Infection Control Program in alignment with the EP. In addition, the facility has developed the following Infection Control auditing forms in July 2007: 1. MSH IC MRSA Auditing Form 2. MSH IC Immunization Refusal Auditing Form 3. MSH IC Immunization Auditing Form 4. MSH IC Hepatitis C Auditing Form 5. MSH IC Annual PPD Auditing Form 6. MSH IC Admission PPD Auditing Form 7. MSH IC Refused PPD Auditing Form 8. MSH IC Positive PPD Auditing Form 9. MSH IC HIV Positive Auditing Form 10. MSH STD Auditing Form The MRSA, Immunization, Hepatitis C, Annual and Admission PPD, and positive PPD auditing tools have been recently implemented. Data collection using the other tools is scheduled to begin in August 2007. Since MSH's Infection Control Department does three-month retroactive auditing, the target population (N) represents the number of individual who had a particular infection or communicable disease three months prior to the month of the audit. The three-month period

of time is necessary to ensure that procedures are followed, e.g., PPDs are repeated 6-8 weeks after an initial negative.

The following table summarizes MSH's data regarding individuals with MRSA (N) and appropriate notifications. Data reported in July all of the known cases of MRSA from December 2006-March 2007.

IC MRSA Auditing Form

	Jul
N: All individuals with a positive culture for MRSA 3 months prior to the month of audit)	12
n: Actual number of audits	5
%S	42
%C	
1. Notification by the lab was made to the Public Health Office of a positive culture for MRSA (F.8.a.i).	100
2. Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained (F.8.a.i).	100

The facility did not collect data for August.

From my review of one individual with MRSA (OV), I found that all the appropriate notifications were made.

MSH reported that there were no reports of immunization refusals or PPD refusals to the Public Health Office during the month of April (April refusals are reported in July since that is the month of audit). Thus, there was no data for these two areas.

In addition, as of September 2007, MSH's STD screening on admission will include Gonorrhea and Chlamydia in both males and females. Data regarding this area will be provided during the next MSH review.

The following table summarizes MSH's admission immunization data:

IC Immunization Auditing Form

	Jul	Aug	Mean
N: All admissions 3 months prior to the month of audit	41	36	
n: Actual number of audits	11	9	
%S	27	25	
%C			
1. Notification by the lab was made to the Public health Office of their immunity status (F.8.a.i).	100	100	100
2. Notification by the lab was made to the unit housing the individual of their immunity status (F.8.a.i).	9	89	45

From my review of immunizations for four individuals (RF, DS, NJ, and JK) I found one (DS) that did not contain unit housing notification.

MSH reported that although only four individuals tested positive for Hepatitis C in April 2007, a total of eight audits were done because the N was so small. Individuals who had been previously identified to be positive were also audited to assess the utility of the monitoring tool. Thereafter, MSH Infection Control Department's target is a 100% audit of individuals who test positive for Hepatitis C during the target month (i.e. three months prior to the reporting month).

IC Hepatitis C Auditing Form

	Jul	Aug	Mean
N: All individuals with positive Hepatitis C antibody test 3 months prior to the month of audit)	8	7	
n: Actual number of audits	8	6	
%S	100	86	
%C			
1. Notification by the lab was made to the Public Health Office of a positive Hepatitis C Antibody (F.8.a.i)	100	100	100
2. Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test (F.8.a.i)	63 5/8	83 5/6	71

The following table summarizes MSH's data regarding individuals' annual PPDs (N) and notification of the Public Health Office.

IC Annual PPD Auditing Form

	Jul	Aug	Mean
N: All individuals requiring annual physical 3 months prior to the month of audit	41	45	
n: Actual number of audits	22	31	
%S	54	69	
1. Notification by the clinic/unit via a PPD form is sent to the Public Health Office for all PPD readings (F.8.a.i).	95	90	92

%C		

The following table summarizes MSH's data regarding admission PPDs:

IC Admission PPD Auditing Form

	Jul	Aug	Mean
N: All admissions 3 months prior to the month of audit	41	36	
n: Actual number of audits	22	18	
%S	54	50	
%C			
1. Notification by the admission unit via a PPD form is sent to Public Health Office for all PPD readings (F.8.a.i).	100	94	96

The following table summarizes MSH's data regarding individuals with positive PPDs and notification to the Public Health Office.

IC Positive PPD Auditing Form

	Jul	Aug	Mean
N: All positive PPD on admission and annual 3 months prior to month of audit)	5	15	
n: Actual number of audits	5	15	
%S	100	100	
%C			
1. Notification by the PPD nurse via a PPD form is sent to Public Health Office for all PPD readings (F.8.a.i).	100	100	100

(All individuals with a history of positive PPD one year or more prior are

		included in this group.) **Recommendations:** 1. Continue to implement monitoring instruments in alignment with the EP. 2. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as F.8.a.i. **Findings:** From my discussion with the Infection Control staff and the Acting Medical Director, it was agreed that data regarding this requirement would be provided in a narrative format, such as minutes of the Infection Control meeting, to better demonstrate how the facility is meeting this requirement. The data that was provided by MSH in table format did adequately address this requirement. **Current recommendation**: Provide data for this requirement in narrative form demonstrating assessment of trends by the Infection Control Department.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as F.8.a.ii. **Findings:** Same as F.8.a.ii **Current recommendation**:

<table>
<tr><td></td><td></td><td>See F.8.a.ii</td></tr>
<tr><td>F.8.a.iv</td><td>identifies necessary corrective action;</td><td>
Current findings on previous recommendation:

Recommendation, March 2007:
Same as F.8.a.ii.

Findings:
The following table summarizes MSH's data regarding individuals with MRSA and the corrective action items listed on the table:

IC MRSA Auditing Form
<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Mean</td></tr>
<tr><td>N: All individuals with a positive culture for MRSA 3 months prior to the month of audit</td><td>12</td><td>2</td><td></td></tr>
<tr><td>n: Actual number of audits</td><td>5</td><td></td><td></td></tr>
<tr><td>%S</td><td>42</td><td></td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td></tr>
<tr><td>3. The individual is placed on contract precaution per MRSA policy (F.8.a.iv).</td><td>80</td><td></td><td></td></tr>
<tr><td>4. The appropriate antibiotic was ordered for treatment of the infection (F.8.a.iv)</td><td>80</td><td></td><td></td></tr>
<tr><td>5. The Public Health Office contacts the unit RN and provided MRSA protocol and guidance for the care of the individual(F.8.a.iv)</td><td>40</td><td></td><td></td></tr>
</table>
IC Immunization Auditing Form
<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>Mean</td></tr>
</table>
</td></tr>
</table>

N: All admissions 3 months prior to the month of audit)	41	36	
n: Actual number of audits	10	9	
%S	24	25	
%C			
3. Immunizations were ordered by the physician within 90 days (F.8.a.iv).	100	100	100

From my review of physician orders for 12 individuals (RF, MP, CA, DS, OV, RP, JK, MA, NJ, LW, LM, and GS), all 12 had an order for immunizations.

IC Annual PPD Auditing Form

	Jul	Aug	Mean
N: All individuals requiring annual physical 3 months prior to the month of audit	41	45	
n: Actual number of audits	22	31	
%S	54	69	
%C			
2. PPDs were ordered by the physician during the annual review procedure (F.8.a.iv).	95	100	98

N = Only individuals who had a negative TST no more than one year ago.

From my review of seven individuals' annual physicals (TM, CL, CW, NM, AW, MC, and LW) all seven had an order for an annual PPD.

IC Admission PPD Auditing Form

	Jul	Aug	Mean
N: All admissions 3 months prior	41	36	

		to the month of audit n: Actual number of audits %S %C 2. PPDs were ordered by the physician during the admission procedure (F.8.a.iv).

to the month of audit			
n: Actual number of audits	21	18	
%S	51	50	
%C			
2. PPDs were ordered by the physician during the admission procedure (F.8.a.iv).	100	94	97

From my review of 10 individuals admitted to MSH in July 2007 (JM, CK, CJ, JB, JP, RO, TC, JJ, LO, and IC), all 10 had an order upon admission for a PPD.

IC Positive PPD Auditing Form

	Jul	Aug	Mean
N: All positive PPD on admission and annual 3 months prior to month of audit)	5	15	
n: Actual number of audits	5	15	
%S	100	100	
%C			
2. All positive PPDs received PA chest x-ray (F.8.a.iv).	80	85	83
3. All positive PPDs receive an evaluation by the public health clinic physician. (F.8.a.iv)	100	92	94

(All individuals with a history of positive PPD one year or more prior are included in this group.)

From my review of three individuals with a positive PPD (RF, CA, and DS), one individuals refused the chest x-ray (RF), and one individual's documentation indicated that the public health physician did a chart review rather than seeing the individual (DS).

<table>
<tr>
<td></td>
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<td>
IC Hepatitis C Auditing Form
<table>
<tr><td></td><td>Jul</td><td>Aug</td><td>M</td></tr>
<tr><td>N: All individuals with positive Hepatitis C antibody test 3 months prior to the month of audit</td><td>8</td><td>7</td><td></td></tr>
<tr><td>n: Actual number of audits</td><td>8</td><td>6</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>86</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td></tr>
<tr><td>3. The individual's Medication Plan was evaluated and immunizations for Hepatitis A and B were considered (F.8.a.iv).</td><td>86
6/8</td><td>33
2/6</td><td>62</td></tr>
</table>
Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.8.a.v</td>
<td>monitors to ensure that appropriate remedies are achieved; and</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2007:
Same as F.8.a.i.

Findings:
The following tables summarize MSH's data regarding MRSA, Immunizations, PPDs, and Hepatitis C respectively and the appropriate remedies listed on each of the tables:

IC MRSA Auditing Form
<table>
<tr><td></td><td>Jul</td></tr>
<tr><td>(All individuals with a positive culture for MRSA 3 months prior to the month of audit)
N</td><td>12</td></tr>
</table>
</td>
</tr>
</table>

Actual number of audits n	5
%S	42
%C	
6. A Focus 6 is opened for MRSA (F.8.a.v).	40
7. Appropriate objective(s) written to include contact prevention of spread of infections (F.8.a.v).	20
8. Appropriate interventions written to include contact precautions (F.8.a.v)	20
9. There was no spread of MRSA to other individuals in his/her environment (F.8.a.v).	100

The facility did not collect data for August.

From my review of one individual with MRSA (OV), I found that there was an opened issue for Focus 6 with appropriate objectives and interventions included in the WRP.

IC Immunization Auditing Form

	Jul	Aug	Mean
N: All admissions 3 months prior to the month of audit	41	36	
n: Actual number of audits	5	4	
%S	12	11	
%C			
4. Immunizations were administered by the nurse within 90 days (F.8.a.v).	60	75	67

From my review of 12 individuals (RF, MP, CA, DS, OV, RP, JK, MA, NJ, LW, LM, and GS), seven were administered within 90 days.

IC Annual PPD Auditing Form

	Jul	Aug	Mean
N: All individuals requiring annual physical 3 months prior to the month of audit	41	45	
n: Actual number of audits	22	31	
%S	54	35	
%C			
3. PPDs were administered by the nurse as ordered (F.8.a.v).	95	97	96
4. PPDs were read by the nurse as ordered (F.8.a.v).	95	90	92

From my review of seven individuals' annual physicals (TM, CL, CW, NM, AW, MC, and LW) all seven had their PPDs administered and read.

IC Admission PPD Auditing Form

	Jul	Aug	Mean
N: All admissions 3 months prior to the month of audit	41	36	
n: Actual number of audits	21	18	
%S	51	50	
%C			
3. PPDs were administered and read by the nurse as ordered (F.8.a.v).	95	78	87

From my review of 10 individuals admitted to MSH in July 2007 (JM,

CK, CJ, JB, JP, RO, TC, JJ, LO, and IC), all 10 had their PPDs administered and read.

IC Positive PPD Auditing Form

	Jul	Aug	Mean
N: All positive PPD on admission and annual 3 months prior to month of audit	5	15	
n: Actual number of audits	5	15	
%S	100	100	
%C			
3. All positive PPDs received an evaluation by the public heath clinic physician (F.8.a.v).	100	100	
4. There is a Focus 6 opened (F.8.a.v).	40	38	39
5. There are appropriate objectives written to provide treatment and prevent the disease (F.8.a.v).	0	9	7
6. There are appropriate interventions written to prevent the progression to disease (F.8.a.v)	33	9	14

(All individuals with a history of positive PPD one year or more prior are included in this group.)

From my review of three individuals with a positive PPD (RF, CA, and DS), none of the three had Focus 6 opened regarding this issue.

IC Hepatitis C Auditing Form

	Jul	Aug	Mean
N: All individuals with positive	8	7	

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>Hepatitis C antibody test 3 months prior to the month of audit</td><td></td><td></td><td></td></tr>
<tr><td>n: Actual number of audits</td><td>8</td><td>6</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>86</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td></tr>
<tr><td>4. A Focus 6 is opened for Hepatitis C (F.8.a.v).</td><td>63</td><td>80</td><td></td></tr>
<tr><td>5. Appropriate objective(s) are written to monitor treatment as required by the Hepatitis C protocol (F.8.a.v).</td><td>25</td><td>0</td><td></td></tr>
<tr><td>6. Appropriate interventions are written to include treatment as required by the Hepatitis C protocol (F.8.a.v).</td><td>25</td><td>0</td><td></td></tr>
</table>

From my review of two individuals with Hepatitis C (RP, JK), I found that both had a Focus 6 problem opened. However, the objectives and interventions were not appropriate.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.8.a.vi</td>
<td>integrates this information into each State hospital's quality assurance review.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Same as F.8.a.i.

Findings:
Although the MSH Infection Control Department reports to Standards Compliance every four months and provides them the results of their Hand Washing survey, Gastroenteritis data, and Minutes of Infection</td>
</tr>
</table>

		Control Committee meetings, data need to be provided supporting this requirement. **Current recommendation**: Provide data to demonstrate compliance with this requirement.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Dr. Toni Nguyen, DDS Reviewed: 1. MSH Dental Clinic Policy and Procedure Manual (draft) 2. Extraction Data monitoring tool 3. WRP Dental Refusal Issues tool 4. Dental progress notes for the following 23 individuals: SL, GW, QV, EF, FG, LP, PS, GC, TB, PT, AA, JN, RP, EC, DP, ST, TS, EC, RM, BC, HF, DA, and KW 5. MSH's Dental progress report and data
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Secure the services of an additional assistant/clerical position. **Findings:** MSH has hired a retired dental assistant as an annuitant for one day a week. In addition, MSH does not have a Chief Dentist position to coordinate and address administrative issues. Consequently, the responsibility for implementation of the EP has been left to the staff dentists, in particular Dr. Nguyen. These duties have taken time away from the care of the individuals. The facility needs to consider adding a Chief Dentist position to assist with EP and administrative duties. **Recommendation 2, March 2007:** Continue the process of obtaining a dental software program.

Findings:
The dental departments in all four facilities have reviewed three different dental software programs: VISTA dental, Dentrix, and Eaglesoft. A final selection has not yet been made. However, funds have been allocated by the State for the computer hardware for the dental clinic.

Recommendation 3, March 2007:
Include percentages and numbers of individuals regarding data indicating noncompliance with timely annual and 90-day exams and include number of individuals that account for refusals in these categories.

Findings:
The tables below summarizes MSH's data regarding new admissions (N) each month that are due for dental exams within 90 days and annual dental exams (N). Individuals that were admitted and discharged before the 90-day period ended or were discharged before their annual exam was due were not included in the data. MSH's compliance data for April was low due to an assistant being out sick. Consequently, the clinic was only operating at a 50% capacity during that month. Overall, the main reason for noncompliance with this requirement is due to individuals' refusals (76% and 71% for the 90-day and annual exams respectively).

90-DAY EXAMS
N= # of admits due for 90day exam (admitted 3 months previously)

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Mean
N	41	33	20	36	34	32.8
n	41	33	20	36	34	32.8
%S	100%	100%	100%	100%	100%	100%
%C	76%	57%	75%	80%	79%	73%
% of non compliance	73%	71%	80%	100%	57%	76%

due to refusals							

ANNUAL EXAM
N= # of annual exams due each month

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Mean
N	35	46	47	27	31	37.2
n	35	46	47	27	31	37.2
%S	100%	100%	100%	100%	100%	100%
%C	60%	58%	60%	70%	53%	60%
% of non-compliance due to refusals	78%	77%	47%	88%	64%	71%

From my review of 13 admission dental exams (RM, RP, BC, PT, TB, CE, HF, JN, AA, LP, DA, KW, PS) and nine annual dental exams (SL, GW, QV, EF, FG, DP, TS, EC, GC), all were completed in a timely manner. Unfortunately, until the WRPTs begin to address individuals who refuse dental appointments, dental will not be in compliance with this requirement.

Recommendation 4, March 2007:
Continue to monitor this requirement and specify target population, actual population reviewed and sample size.

Findings:
The following table summarizes MSH's data regarding individuals who were seen for dental emergencies (N) within 24 hours.

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Mean
N	10	9	2	15	14	10
n	9	9	2	15	14	9.8
%S	90%	100%	100%	100%	100%	98%
%C	89%	100%	100%	100%	93%	96%

N= # of emergency referral each month

n= # of emergency referral reviewed each month

The following table summarizes MSH's compliance data regarding timely response to referrals for routine dental treatment. The low compliance score in April was due to a staffing issue in the Dental Clinic.

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Mean
N	30	28	24	26	17	25
n	30	28	24	26	17	25
%S	100%	100%	100%	100%	100%	100%
%C	93%	61%	96%	96%	100%	89%

N= # referral for routine care each month

n= # of routine referral cases reviewed each month

From my review of 9 individuals who had routine dental care (SL, GW, QV, EF, FG, DP, TS, EC, GC), all were seen in a timely manner.

Compliance:
Partial.

		Current recommendations: 1. Evaluate the need for a Chief Dentist position. 2. Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Review and revise policies and procedures as needed to address this requirement. **Findings:** The MSH Dental Clinic Policy and Procedures Manual is currently being revised. From my review of a draft of the manual, appropriate timeframes have been designated for the provision of dental services for admission exams, annual exams, and emergencies. However, there was no mention of dentists' documentation requirements regarding comprehensive dental exams or tooth extractions. As I have found in all the facilities, the dental notes basically describe what treatment/service was provided to the individual. In most cases I could not determine from the documentation the actual dental needs of the individuals. Cell F.9.b.iv describes documentation issues found during this review regarding extractions. In addition, the language in the draft manual is not in alignment with Wellness and Recovery. For example, "patient" is used throughout the manual rather than "individual." **Recommendation 2, March 2007:** Continue to monitor this requirement and specify total target population, population reviewed and sample size.

Findings:
The table below summarizes MSH's compliance data regarding individuals who were seen each month (N) and whose dental treatments were completed. Individuals who refused treatments and/or have not completed their dental treatments were scored as being noncompliant. As dental refusers are addressed by the WRPTs and work is completed for individuals who have more extensive dental needs, compliance rates should increase.

N= the number of individuals who had their dental exam done that month.
n= number of charts reviewed

	Mar-07	Apr-07	May-07	Jun-07	MEAN
N	45	50	44	46	46
n	45	50	44	46	46
%S	100%	100%	100%	100%	100%
%C	50%	49%	91%	87%	69%

From my review of 21 individuals' dental notes (SL, GW, QV, EF, FG, LP, PS, TB, PT, AA, JN, RP, EC, DP, ST, EC, RM, BC, HF, DA, and KW), I found it difficult to find a documented treatment plan that outlined the dental needs for each individual to monitor this requirement. Some of the notes indicated that additional work was to be scheduled for issues such as extractions. However, these notes were not consistently found in the records. I did find documentation indicating that two individuals (EC and RP) refused the prescribed treatments.

The table below summarizes MSH's compliance data regarding timely responses to referrals for routine dental treatment (N). A staffing issue was cited as the reason for the low compliance rate in April.

N= # referral for routine care each month
n= # of routine referral cases reviewed each month

	March-07	April-07	May-07	June-07	July-07	Mean
N	30	28	24	26	17	25
n	30	28	24	26	17	25
%S	100%	100%	100%	100%	100%	100%
%C	93%	61%	96%	96%	100%	89%

From my review of five individuals (EF, FG, DP, JN, and HF) who were referred for dental treatment, one (EF) was not seen in a timely manner.

Current recommendations:

1. Continue to revise the Dental Clinic Policy and Procedures Manual to include the documentation requirements for dental services regarding comprehensive exams and extractions and Wellness and Recovery language.
2. Ensure dentists clearly document their dental treatment plans.
3. Continue to monitor this requirement.

F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement and specify total target population and population reviewed. **Findings:** The data provided by MSH did not adequately address the elements of this requirement. In addition, as noted from my review in F.9.b.i, I found that plans of care were not consistently documented in the dental records. However, the documentation of treatment provided was consistently found in all 21 dental records that I reviewed.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Report data for each element of this requirement separately.
2. Continue to monitor this requirement.</td></tr>
<tr><td>F.9.b.iii</td><td>use of preventive and restorative care whenever possible; and</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Secure the services of an additional assistant/clerical position.

Findings:
See F.9.a.

Recommendation 2, March 2007:
Continue to monitor this requirement and specify total target population (vs. population reviewed) and sample size for each month.

Findings:
The tables below summarize MSH's compliance data regarding the number of individuals who were seen in the Dental Clinic (N) and needed preventative and restorative dental treatments. Individuals who refused preventative/restorative treatment and those who were discharged were not included in the data.

Preventative Treatment

<table>
<tr><th></th><th>Apr-07</th><th>May-07</th><th>Jun-07</th><th>MEAN</th></tr>
<tr><td>N</td><td>32</td><td>37</td><td>37</td><td>35</td></tr>
<tr><td>n</td><td>32</td><td>35</td><td>35</td><td>34</td></tr>
<tr><td>%S</td><td>100%</td><td>95%</td><td>95%</td><td>97</td></tr>
<tr><td>%C</td><td>93%</td><td>92%</td><td>90%</td><td>92%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>From my review of seven individuals' dental records (EF, FG, DA, DP, DA, KW, and TS), one (EF) did not have documentation that preventative care was provided.

Restorative Treatment
<table>
<tr><th></th><th>Apr-07</th><th>May-07</th><th>Jun-07</th><th>MEAN</th></tr>
<tr><td>N</td><td>19</td><td>15</td><td>15</td><td>16</td></tr>
<tr><td>n</td><td>18</td><td>15</td><td>14</td><td>15</td></tr>
<tr><td>%S</td><td>95%</td><td>100%</td><td>93%</td><td>96%</td></tr>
<tr><td>%C</td><td>83%</td><td>78%</td><td>87%</td><td>83%</td></tr>
</table>
From my discussion with Dr. Nguyen, the above data represents individuals who have not completed all their dental treatments since it may take a number of months to have all the work completed. This data does not represent individuals who have dental restorative needs that are not being addressed. It was agreed that this data needed to be collected and monitored.

Current recommendations:
1. Develop and implement a system to identify and track individuals who are not getting their dental needs met.
2. Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
The table below is a summary of Metro's compliance data regarding tooth extractions used as a treatment of last resort. MSH indicated that each</td>
</tr>
</table>

extraction case was reviewed to make sure that there was evidence (x-ray or explanation) to determine that tooth extraction was the last treatment resort (i.e. tooth is non-restorable or major bone loss with mobility +1,+2)

N= # extraction treatment given each month
n= # of extraction cases reviewed each month

	March-07	April-07	May-07	June-07	July-07	Mean
N	17	33	24	14	13	20.2
n	17	33	24	14	13	20.2
%S	100%	100%	100%	100%	100%	100%
%C	100%	100%	100%	100%	100%	100%

From my review of the medical records of 13 individuals who had tooth extractions (SL, GW, QV, EF, FG, LP, PS, TB, PT, AA, JN, RP, EC), I found that three (EF, RP and PT) had some clinical justifications documented in the dental progress notes. In the case of RP, the documentation from the dentist indicated that his tooth was restorable. However, the documentation indicated that the individual refused the restorative treatment and insisted that the tooth be extracted. However, for the remaining 10, I found no clinical justification documented in the dental notes.

From my discussion with Dr. Nguyen, the dentists have been reviewing the x-rays and using their clinical judgment to determine compliance with this requirement. It was agreed that the dental notes would contain the clinical justification for tooth extractions and the specific criteria to justify extractions would be included in a monitoring instrument to assess compliance.

		Current recommendations: 1. Develop and implement a monitoring instrument addressing specific clinical criteria justifying tooth extractions. 2. Ensure MSH dentists are retrained to include the clinical criteria for extractions in their progress notes. 3. Continue to monitor this requirement.
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to monitor this requirement. **Findings:** The data provided by MSH did not address the elements of this requirement. The tool to monitor this cell was omitted. After discussion regarding the need to have a monitoring instrument addressing all the elements of this requirement, a new tool was developed during the week of this review. It was agreed that data collection will be started and data provided at the next visit. **Compliance:** Partial. **Current recommendations**: 1. Ensure that each element of this requirement is addressed in the monitoring instrument. 2. Report compliance data for each element of this requirement separately. 3. Monitor compliance with this requirement.
F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and	**Current findings on previous recommendations:**

individuals' refusals are addressed to facilitate compliance.

Recommendation 1, March 2007:
Continue to monitor this requirement.

Findings: The following table summarizes data regarding missed dental appointments (N) and the reason identified by the items listed below:

a. Cancellation by clinic (usually unscheduled sick leave by clinic staff)
b. Transportation
c. Unit Acuity (lock down etc…)
d. Lack of Staff from the unit for 1:1 Individual
e. Individual not available when being picked up by escorts due to various reasons (out to court, on grounds, IT work, outside hospitalization for acute medical care, the medical charts are being reviewed by other departments and are not available, etc
f. Individual's refusals
g. Individual's behavior prevent him/her from attending dental appointments

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	MEAN
N	75	68	65	46	82	67.2
n	75	68	65	46	82	67.2
%S	100%	100%	100%	100%	100%	100%
a	0%	4%	1%	17%	20%	8%
b	0%	0%	0%	0%	0%	0%
c	1%	0%	0%	0%	0%	0%
d	1%	3%	0%	2%	1%	1%
e	11%	12%	14%	17%	20%	15%
f	84%	81%	85%	63%	54%	73%
g	3%	1%	0%	0%	5%	2%

		Recommendation 2, March 2007: Develop and implement corrective actions based on results of this monitoring. **Findings:** The data indicated that transportation, lack of staff, and unit acuity were not typically the reasons that individuals missed their dental appointments. Refusals accounted for the main reason for Incomplete Scheduled Appointments (73%). MSH will begin tracking the specific reasons for refusals so that the appropriate actions can be taken by the WRPTs to reduce the rate of refusals. This system will also be implemented to track the specific reason that the individual was not available for the appointment. **Compliance:** Partial. **Current recommendations**: 1. Implement a system to monitor and track reasons for dental refusals and unavailability for dental appointments. 2. Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop and implement a policy/procedure addressing the process of dental refusals and conduct staff in-services. **Findings:** As part of the Dental Clinic Policy and Procedure Manual revisions, MSH developed a policy addressing refusal issues. However, the policy needs to be expanded with input from other disciplines to adequately address this issue.

Recommendation 2, March 2007:
Continue to develop and implement a facility-wide system to facilitate communication between dental and the WRPTs regarding individualized strategies to address refusals of dental appointments and treatments.

Findings:
The MSH dental and psychology staffs have begun a process to determine the reason for refusals and forward this information to the WRPT and the unit psychologist to address this with the individual. This system has not yet been fully implemented.

Recommendation 3, March 2007:
Continue to monitor this requirement.

Findings:
The following table summarizes data from the previous procedure addressing dental refusals. The procedure included sending a refusal memo to the unit psychiatrist asking for intervention regarding the individual refusing his/her dental treatment. The number of responses sent back to the dentists was 24%. As a result, MSH is developing a new policy/procedure addressing dental refusals.

	Mar-07	Apr-07	May-07	Jun-07	Jul-07	MEAN
N	11	29	11	11	no	15
n	11	29	11	11	data	15
%S	100%	100 %	100%	100%		100%
%C	0%	24%	45%	27%		24%

		Compliance: Partial. **Current recommendations**: 1. Expand and implement the policy regarding dental refusals. 2. Monitor the elements of this requirement.

10. Special Education		
	Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.	**Methodology:** Interviewed: 1. Marilu Tiberi-Vibrai, Assistant Chief, Central Program Services 2. Pam Lopez, Assistant Chief, CPS, Education 3. Jean Lowery, School Psychologist 4. Jennifer Miller, Principal Reviewed: 1. MSH Enhancement Plan (Special Education, Section F.10; August, 2007) – including Psycho Educational Assessment Audits; Individual Education Plan Audit Interviews; Individual Education Plan Meeting Audits; Individual Education Plan Review Tools; Curriculum-based measurement (CBM) data; teacher interviews; staff development logs and schedule; staff development invoices; etc. 2. Individualized Education Plans (SM, MR, MR, RF, RD, DT, and JL) 3. Behavior support plans (SM, MR, RF, RD, DT, and JL)
F.10.a	Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Use modified and newly created assessment tools (Psycho-Educational Assessment Audit, Individual Education Plan Audit Interview, Individual Education Plan Meeting Audit, and Individual Education Plan Review Tool) to continue to monitor compliance. **Findings:** Assessment tools used to monitor compliance, and data aggregated across months. Timeline issues that were so prevalent in the initial report were not noted in the IEPs that were reviewed. Two areas of concern were noted from data collected. First, item 6 ("For a student

		with limited English proficiency, did the IEP team consider the language needs of the student as such needs related to the IEP") on the IEP Document Review Tool and item 2 ("All required team members were present") on the IEP Meeting Audit indicated areas in need of improvement. While IEP reviews indicated appropriate participation of school personnel, families, and students in the IEP process, treatment team members (e.g., Psychiatry) were not represented at these meetings, affecting the data reported on the Audit tool. **Recommendation 2, March 2007:** Use students' IEP annual goals and short-term objectives to inform instruction in the classroom. **Findings:** IEP annual goals and short-term objectives remain improved from the initial report. Annual goals frequently are not developmentally appropriate based upon the reported ability level of students. In addition, short-term objectives often are redundant and therefore not helpful in planning classroom instruction. Notable exceptions from the IEP review included DT's vocational goals and the reading, writing, and mathematics goals and objectives for DT and RD. Last, terminology in IEPs (as well as behavior support plans) is often unclear and needs to be better operationalized to allow for valid data collection as well as instructional and behavioral planning. **Recommendation 3, March 2007:** Use curriculum-based measurements (CBM) to collect data weekly on student progress in math, reading, and writing, ensuring that data collected is valid and based upon standardized measurement procedures. **Findings:** CBM data is being collected, graphed, and reported. The quality and

		validity of the data collected continues to vary across teachers and students. It does not appear that standardized measurement procedures are being used. **Recommendation 4, March 2007:** Use behavior support plans to provide some consistency for students across settings; teachers should become familiar with target (i.e., replacement) behaviors and antecedent and consequent events that can promote and reinforce the use of desired replacement behavior. **Findings:** The content of the behavior support plans has improved. Positive behavior supports are listed within the plans and include recommendations for antecedent and consequent manipulation as well as environmental modifications. More focus on behavioral processes and less on internal characteristics would be helpful in recommending supports that have an increased likelihood of success in the school setting. Terms in behavior support plans (e.g., acting out, acting appropriately, interacting appropriately) are not operationally defined. **Recommendation 5, March 2007:** Use behavioral data to modify instruction to better meet students' needs. Use decision rules to indicate when a change in instructional method/delivery is made; document what changes are made. **Findings:** While CBM data is being collected on students' academic progress and a plan is in place to begin collecting and tracking behavioral data across settings, the questionable validity of collected data indicates that the data is not ready to be used to make instructional decisions. **Other findings:** Goals on Transition Plans within IEPs often mirror academic goals and

		objectives. **Compliance:** Partial. **Current recommendations:** 1. Aggregate data per item on assessment tools across time to allow for more discrete identification of areas in need of improvement 2. Ensure that the IEP team considers the language needs of students with limited English proficiency as it relates to the IEP 3. Ensure that all required team members are present at IEP meetings 4. Write annual goals on the IEP that are both measurable and achievable. 5. Write short-term objectives that are measurable, not redundant, and contribute to the achievement of annual goals. 6. Behavioral terms in IEPs and BSPs should be operationalized to allow for valid data collection. 7. Improve validity of CBM data; provide sample protocols and probes. 8. Write transition plans that include functional skills.
F.10.b	Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq. (2002) ("IDEA").	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue providing high-quality professional development to teachers and staff. **Findings:** The staff development training schedule, signature pages for trainings, and meeting agendas indicate that quality professional development is both being offered to and attended by staff. **Recommendation 2, March 2007:** Ensure that IEP annual goals and objectives are measurable and tied to

		classroom assessment data. **Findings:** Data from the IEP Review Audit and IEP Document Review Audit tools indicates that IEP annual goals and objective are measurable. Review of the IEPs indicates that while goals may be measurable, they often are not achievable within a year's time, and short-term objectives are often redundant. Further, given the lack of validity of CBM data, tying this data to goals and objectives is not possible at this time. **Other findings:** Goals within transition plans often mirror academic goals verbatim. **Compliance:** Partial. **Current recommendations:** 1. Continue providing high-quality professional development to teachers and staff. 2. Write achievable annual goals. 3. Write measurable short-term objectives relevant to achieving annual goal. 4. Write functional goals within transition plans.
F.10.c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Provide opportunities for teachers and staff to seek professional development (e.g., graduate coursework, workshops) beyond that provided by MSH. **Findings:** Invoices indicate that some teachers and staff have had professional

		development opportunities beyond that provided by MSH. **Recommendation 2, March 2007:** Provide targeted training to volunteers based upon their interest, skills, and relationships with students. For example, providing reading tutoring skills in fluency training might be appropriate for one volunteer, while training in comprehension strategies might be appropriate for another. **Findings:** A training on reading tutoring, scheduled for July 13, 2007, has been rescheduled for September 18, 2007. **Compliance:** Partial. **Current recommendations:** 1. Continue to provide professional development opportunities for staff and teachers beyond that provided by MSH. 2. Provide targeted training to volunteers based upon their interest, skills, and relationships with students. For example, providing reading tutoring skills in fluency training might be appropriate for one volunteer, while training in comprehension strategies might be appropriate for another.
F.10.d	Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Include teachers as well as students in the development of behavior support plans. **Findings:** Review of BSPs indicates teacher signatures are on the plans.

		Recommendation 2, March 2007: Include annual goals and short-term objectives for self-determination skills in IEPs. **Findings:** Data from IEP Meeting Audit form indicates that self-determination was discussed in IEP meetings. Data from IEPs, however, indicates that self-determination goals and objectives are not being included in IEPs. A new self-determination curriculum has been ordered and should be implemented during the 2007-2008 school year. **Recommendation 3, March 2007:** Provide targeted training to volunteers based upon their interest, skills, and relationships with students, particularly in tutoring. **Findings:** Training scheduled for July 13 has been rescheduled for September 18. **Compliance:** Partial. **Current recommendations:** 1. Continue to make every attempt to involve both teachers and students in the development of BSPs. 2. Implement self-determination curriculum with integrity 3. Include self-determination goals and objectives on IEP 4. Provide targeted training to volunteers based upon their interest, skills, and relationships with students, particularly in tutoring.
F.10.e	Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for	**Current findings on previous recommendations:**

	students who show deficits in one or more common areas of reading (e.g., decoding or comprehending).	**Recommendation 1, March 2007:** Training and materials should be provided to allow teachers to use direct instruction to teach reading to those students who are struggling. **Findings:** Training on research-based strategies for effective academic instruction was provided on May 7, 2007. **Recommendation 2, March 2007:** Training and materials should be provided to allow teachers to use fluency training to help struggling readers. **Findings:** No documentation was provided of instruction to staff and teachers in fluency training; some material from the May 7 training may have overlapped with this area. **Recommendation 3, March 2007:** Training and materials should be provided to allow teachers to use comprehension strategies to help struggling readers. **Findings:** Training on evidence-based comprehension strategies was provided to staff and teachers on April 23, 2007; a future training session on reading comprehension and writing strategies is scheduled for November 11. **Recommendation 4, March 2007:** Training and materials should be provided to allow teachers to use writing instruction methods with a research base to help struggling writers.

		Findings: Training on research-based strategies for effective instruction was provided to staff and teachers on May 7. AIMS Web Training took place on July 26 and 27, 2007. A training session on reading comprehension and writing strategies is scheduled for November 11. **Recommendation 5, March 2007:** Continue to use CBM to improve instruction. Teachers should attend trainings to ensure that they implement CBM procedures correctly, increasing the validity of the data collected. **Findings:** Teachers are collecting CBM data but the data is of questionable validity. Trainings are scheduled and will take a more focused, developmental, competency-based approach in the coming months. **Recommendation 6, March 2007:** As the validity of the data collected improves, teachers should begin to use this data to inform their instruction. **Findings:** Data is not valid, thus it cannot be used to inform instruction. **Recommendation 7, March 2007:** Teachers should begin having students graph their own CBM data on Excel spreadsheets. **Findings:** Staff are not prepared to move to this stage yet as they are still establishing procedures for teachers to collect data. **Recommendation 8, March 2007:** One teacher does not have access to a computer; computer should be

		provided to this teacher so he can allow his students to self-graph. **Findings:** The necessary computer was installed on May 7. **Recommendation 9, March 2007:** Goals and objectives in literacy should continue to be refined. Using CBM data can make these measurable and more closely match individual students' needs (e.g., some students may need a goal in fluency, while others may read fluently but need a goal in passage comprehension). **Findings:** Annual goals in many cases are not achievable within a calendar year. Short-term objectives are often redundant and not related to annual goal. **Recommendation 10, March 2007:** Provide targeted training to volunteers based upon their interest, skills, and relationships with students, particularly in reading tutoring. **Findings:** Training scheduled for July 13 has been rescheduled for September 18. **Other findings:** Writing goals and objectives on IEPs are often focused on spelling rather than functional writing skills. **Compliance:** Partial. **Current recommendations**: 1. Continue to provide training and materials to teachers and staff so that they can provide evidence-based literacy instruction to

		students. 2. A more focused training program for CBM data collection must be implemented. 3. Teachers must collect valid CBM data. 4. Annual goals on IEPs should be measurable and achievable within one calendar year. 5. Short-term objectives must be measurable, tied to the annual goal, and not redundant. 6. Provide targeted training to volunteers based upon their interest, skills, and relationships with students, particularly in tutoring. 7. Functional writing goals should be included on IEPs.
F.10.f	Each State hospital shall on admission and as statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Document participation of Local Education Agency through use of IEP Document Review Audit Tool (item #11). **Findings:** Data from IEP Document Review Audit (Item #11) indicates full compliance with this recommendation. **Compliance:** Substantial. **Current recommendation**: Continue documenting participation of Local Education Agency through use of IEP Document Review Audit Tool (item #11).
F.10.g	Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical status.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice.

		Findings: Current practice continued. **Other findings:** DT graduated. **Compliance:** Substantial. **Current recommendation:** Continue current practice

G. Documentation		
G		**Summary of Progress:** Please refer to Sections D, E, F and H for judgments on the progress MSH has made towards aligning documentation practices with the requirements of the EP.
G	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Current findings on previous recommendations:** **Recommendations 1-3, March 2007:** 1. Monitor and track the quality of documentation regarding all the required elements in the plan. 2. Address and correct factors related to inconsistent compliance. 3. Provide ongoing training regarding documentation requirements. **Findings:** Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation.

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. Most of MSH's monitoring systems regarding Restraint, Seclusion, PRN and Stat medications have been implemented and data is being regularly collected. 2. Competency-based training for Restraint, Seclusion, PRN, and Stat medications has developed and implemented. 3. The facility is committed to decreasing the use of restraints and seclusion. 4. MSH is actively reviewing its practices regarding the use of side rails and other restraint devices on the Skilled Nursing Units.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Michael Nunley, RN, Standards Compliance Director 2. Carmen Fayloga, RN/HSS <u>Reviewed</u>: 1. MSH AD 3306, Behavioral Seclusion or Restraint 2. NP 250, Behavioral Seclusion or Restraint 3. California Department of Mental Health Special Order 119.06, Seclusion and Behavioral Restraint 4. Staff training rosters for Seclusion and Restraints, Changes in policies and procedures on PRN/Stat Medications and monitoring tools, 5. Seclusion or Restraint Review form and instructions 6. DMH Psychology Services Monitoring form 7. Course Curriculum for Management of Assaultive Behavior 8. Seclusion/Restraints Inter-rater Reliability Study data 9. MSH AD 3133.1, Trigger Response 10. NP 528, PRN Orders and NP 530, Stat Orders 11. Psychiatric Monthly Progress Notes Monitoring instrument

		12. Fall Risk Assessment form 13. Physician Order for Side Rail and Other Devices form 14. Use of Side Rail and Other Device/Equipment Monitoring form and instructions 15. MSH's progress report and data 16. MSH Nursing Education Department curricula for Proactive Techniques to Eliminate Seclusion and Restraints and Protective Devices and Side Rails 17. Falls Committee Charter 18. AD draft for Falls Prevention/Management Program 19. The medical records for the following 22 individuals: TM, CL, CW, DH, LW, MC, NM, AW, CD, JC, GB, JP, RM, KG, EL, DE, LB, DC, TP, EG, HN, HF <u>Observed</u>: 1. Individuals on Unit 419
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Provide staff training regarding revisions to policies and procedures for restraint/seclusion. **Findings:** Staff training rosters provided by MSH verify that training regarding the revisions made to Nursing Policy and Procedure #250, Behavioral Seclusion or Restraint and AD 3306, Behavioral Seclusion or Restraint was provided in May, June, and July 2007. The following data outlines the different nursing staff positions that have attended the training: a) Assistant Coordinators for Nursing Services – 1 out of 5 b) Nursing Coordinators – 100% c) Unit Supervisors – 89%

		d) Health Services Specialists – 96% e) Unit/Level of Care Nursing Staff – 70% f) Nursing Instructors – 3 out of 4 **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** Continue training as needed. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Ensure that staff training regarding changes in policies and procedures for this requirement is provided. **Findings:** Same as above. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** Data regarding restraints and seclusion was separated in June 2007. Up

until that time it was collected and reported together. I only reviewed and included the separated data for Section H, Restraints, Seclusion, and PRN and Stat Medication.

The following tables summarize MSH's compliance data for incidents of restraints and seclusion respectively, (N) and the items listed on the table.

Restraint Review

	June	July	Mean
N = total number of restraint events each month	86	113	
n = number of restraint events audited	75	83	
%S	87	73	
%C			
#1: Behavior justifying.	99	100	100
#10: Documentation describes cause/reason necessitating Seclusion or Restraint.	97	100	99
#11: Least restrictive alternatives are documented .	89	94	92

Seclusion Review

	June	July	Mean
N = total number of seclusion events each month	7	2	
n = number of seclusion events audited	7	2	
%S	100	100	
%C			
#1: Behavior justifying.	100	100	100

#10: Documentation describes cause/reason necessitating Seclusion or Restraint.	100	100	100		
#11: Least restrictive alternatives are documented .	100	100	100		

From my review of the charts of 10 individuals (TM, CL, CW, DH, LW, MC, NM, AW, CD, and JC) who were placed in restraints several times within the past four months, I found that the documentation for two individuals CW and DH) did not support the decision to place the individuals in restraints. In the case of CW and DH, I did not find progress notes addressing when they were initially placed in restraints. In addition, I found that the least restrictive alternatives were usually check-marked on form 1172B except in the case of LW and CW. The section of the form addressing alternative measures was left blank. However, from my review of the progress notes, I did not find a specific description of what other alternatives were tried prior to restraint. My findings do not support MSH's data regarding this issue. The auditors conducting the restraint monitoring need to be trained on appropriate and acceptable documentation criteria.

From my review of WH, CD, and FA who were placed in seclusion within the past four months, I found that the documentation identified that reason for the placement and that alternative measures indicated on the check list form 1172B were also documented in the progress notes.

Current recommendations:

1. Retrain auditors regarding appropriate documentation criteria for restraints and seclusion.
2. Continue to monitor this requirement.

<table>
<tr>
<td>H.2.b</td>
<td>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</td>
<td>
Current findings on previous recommendations:

Recommendation 1, March 2007:
Separate and report data regarding the elements of this requirement.

Findings:
In response to this recommendation, MSH revised the Seclusion or Restraint Review Monitoring Form and broken out the three separate elements of this requirement to reflect the data separately.

Recommendation 2, March 2007:
Continue to monitor this requirement.

Findings:
The following tables summarize MSH's compliance data regarding restraint and seclusion events respectively (N) and the items listed on the table addressing this requirement.

Restraint Review
<table>
<tr><th></th><th>June</th><th>July</th><th>Mean</th></tr>
<tr><td>N = total number of restraint events each month</td><td>86</td><td>113</td><td></td></tr>
<tr><td>n = number of restraint events audited</td><td>75</td><td>83</td><td></td></tr>
<tr><td>%S</td><td>87</td><td>73</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td></tr>
<tr><td>#29: Restraint and seclusion are not used in the absence of, or as an alternative to active treatment.</td><td>94</td><td>76</td><td>85</td></tr>
<tr><td>#30: Restraint and seclusion are not used as</td><td>94</td><td>88</td><td>91</td></tr>
</table>
</td>
</tr>
</table>

punishment.				
#31: Restraint and seclusion are not used for the convenience of staff.	93	86	90	

Seclusion Review

	June	July	Mean
N = total number of seclusion events each month	7	2	
n = number of seclusion events audited	7	2	
%S	100	100	
%C			
#29: Restraint and seclusion are not used in the absence of, or as an alternative to active treatment.	83	83	83
#30: Restraint and seclusion are not used as punishment.	100	100	100
#31: Restraint and seclusion are not used for the convenience of staff.	100	100	100

From my review of the charts of 10 individuals who had restraint events (TM, CL, CW, DH, LW, MC, NM, AW, CD, and JC), I noted that individuals with an Axis II disorder(NM, AW, CL) were placed in restraints for behaviors that were clearly predictable from a review of their medical records. The progress notes indicated similar descriptions of behaviors such as attention-seeking, hostile, manipulative, and testing the rules and limits of the units and staff. However, the WRPs did not include adequate strategies to deal with behaviors that would be expected from individuals who have Axis II personality disorders. The documentation repeatedly

		indicated that when these behaviors occurred, the consistent intervention was the use of restraints. For example, in the case of NM, the documentation indicated that prior to her being placed in restraints, she had a hostile attitude and was attention-seeking and was upset that she could not see or call her family. Shortly after this note was written, she was placed in five-point restraints. There was no indication that staff provided her support when she initially demonstrated signs of distress. In a similar event, the progress notes indicated that NM was attention-seeking and would not wait her turn for a request in the canteen. When told to wait her turn, she physically attacked the staff. However, there were no therapeutic interventions or strategies put in place to deal with her recurring demanding behaviors. During this incident she escalated and was placed in five-point restraints. Similar situations occurred for AW and CL. The documentation indicated that when these individuals became attention-seeking, demanding or did not follow staff's redirection, they escalated and were put into restraints. Consequently, these findings indicate that some events of restraints are being used in place of active treatment and as punishment. **Current recommendations:** 1. Provide staff training regarding Axis II diagnoses. 2. Develop and implement strategies and interventions to therapeutically address behaviors and ensure that they are included in the WRPs. 3. Continue to monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Separate and report data for elements of this requirement.

Findings:
Psychology reported that restraints and seclusion are included in the aversive or punishment contingencies that they monitor in the DMH Psychology Services Monitoring instrument.

Recommendation 2, March 2007:
Continue to monitor this requirement.

Findings:
The table below summarizes MSH's compliance data regarding PBS plans not including aversive or punishment contingencies such as restraint and seclusion.

DMH Psychology Services Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = total number of Individuals with PBS Plans	13	16	15	16	13	
n = number of completed audits of Individuals with PBS Plans	13	16	15	16	13	
%S	100	100	100	100	100	
%C #8. Behavioral interventions, which include Positive Behavior Support Plans, are based on a positive behavior support model, and do not include the use of aversive or punishment contingencies.	100	100	100	100	100	

Current recommendation:
Continue to monitor this requirement.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>H.2.d</td><td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>
Current findings on previous recommendations:

Recommendation 1, March 2007:
Implement interventions to ensure accuracy of the compliance data.

Findings:
To ensure accuracy of the compliance data, MSH provided an inservice in April and May 2007 to 96% of Health Services Specialists (HSSs) (who are the designated auditors) on scoring the Seclusion or Restraint Review Form and the policy revisions regarding seclusion and restraints. The initial Inter-Rater Reliability test among the HSSs was 83%. From my findings and discussion with Nursing and Standards Compliance, it was agreed that further in-service and training need to be conducted with additional inter-rater reliability audits.

Recommendation 2, March 2007:
Continue to monitor this requirement.

Findings:
Restraint Review
<table>
<tr><td></td><td>June</td><td>July</td><td>Mean</td></tr>
<tr><td>N = total number of restraint events each month</td><td>86</td><td>113</td><td></td></tr>
<tr><td>n = number of restraint events audited</td><td>75</td><td>83</td><td></td></tr>
<tr><td>%S</td><td>87</td><td>73</td><td></td></tr>
<tr><td>%C
#15: Individual released when criteria met.</td><td>97</td><td>94</td><td>96</td></tr>
</table>
</td></tr>
</table>

Seclusion Review

	June	July	Mean
N = total number of seclusion events each month	7	2	
n = number of seclusion events audited	7	2	
%S	100	100	
%C #15 Individual released when criteria met.	100	100	100

From my review of WH, CD, and FA who were placed in seclusion within the past four months, I found that the documentation indicated that the individuals were released fairly quickly and appropriately.

From my review of the charts of 10 individuals who had restraint events (TM, CL, CW, DH, LW, MC, NM, AW, CD, and JC), I found five individuals (NM, CL, CW, MC, AW, and DH) whose restraint events were of major concern. In the case of NM, the documentation indicated that while assessing her for release, she was hostile and angry. The noted indicated that she was "to remain in restraints to reflect on her inappropriate behavior." A progress note 45 minutes later indicated that after the physician left, she started to be rude to her 1:1 staff and "remains manipulative and defiant." The note stated that she will be "given more time to gain insight into her inappropriate behavior of mishandling anger and frustration." She was finally released an hour and fifteen minutes after that progress note stating that her rights were restored.

In the case of CL, while in five-point restraints, she was cooperative with using the bedpan and with arm position changes and range of motion. However, she was not released for another 30 minutes. The documentation did not support the length of time she stayed in restraints. In addition, after she was released, she was required to make up the restraint bed.

		In the case of CW, while in five-point restraints the documentation indicated that he was mumbling to himself and in no apparent pain. The note stated that staff would refer him to a psychologist to be evaluated prior to his release and to speak in his preferred language. He was not seen by the psychologist for another two hours and 45 minutes. During that time, there was no indication from the documentation that his behavior warranted keeping him in restraints. In addition, for three individuals (MC, AW, and DH) I found no progress notes documenting when they were released from restraints. **Other findings:** From my review of the form used for the physicians' orders for seclusion and restraint, the only exit criteria noted on the form was a checkmark indicating danger to self (DTS) or a danger to others (DTO). MSH does not use specific and individualized exit criteria. In addition, there are no specific guidelines such as after a period of 15 minutes of demonstrated control, the individual should be released from the seclusion or restraints. These issues need to be addressed. **Current recommendations**: 1. See H.2.a recommendation #1. 2. Identify and document specific exit criteria for seclusion and restraints. 3. Implement guidelines using 15-minute timeframes of demonstrated release criteria to guide staff's decisions regarding releasing individuals from seclusion and restraints. 4. Continue to monitor this requirement.
H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual	**Current findings on previous recommendation:**

placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.

Recommendation, March 2007:
Continue developing and implementing a system to monitor and ensure compliance with all elements of this requirement.

Findings:
MSH's has revised and implemented policies addressing this requirement. In addition, items on the Seclusion or Restraint Review monitoring form address the elements of this requirement.

Also, the Preventive Management of Assaultive Behavior (PMAB) class has a competency-based curriculum and is a required/mandatory training for all direct patient care staff. This training includes the administration of Seclusion and Restraints. The training is provided to all new employees assigned to provide direct patient care and provided annually thereafter. A training database is maintained by the Office of Professional Education and Training. The Information Technology Department and the Office of Professional Education and Training, in cooperation with the Standards Compliance Department, has developed a database to provide a standardized compliance report by topic (e.g., PMAB) and employee class (e.g., Level I – Direct Care Nursing Staff). At the time of this review, 71% of direct care nursing staff had received PMAB training.

The tables below summarize MSH's compliance data regarding events of restraint and seclusion respectively (N) and the items listed on the table. Seclusion and restraint data was separated by MSH in June 2007 and are reported in the separate tables below.

Seclusion or Restraint Review

	Mar	Apr	May	Mean
N = total number of seclusion and restraint events each month	102	86	72	
n = number of seclusion and restraint events	102	83	70	

audited					
%S	100	97	97	
%C				
#4: Physician/Licensed Independent Practitioner conducted a face-to-face evaluation within one hour.	97	98	94	96
#5: Results of Physician/Licensed Independent Practitioner's face-to-face evaluation are documented in the Physician Progress Note.	98	94	91	94
#6: Signature within one hour of order.	99	96	96	97

Restraint Review

	June	July	Mean
N = total number of restraint events each month	86	113	
n = number of restraint events audited	75	83	
%S	87	73	
%C			
#4: Physician/Licensed Independent Practitioner conducted a face-to-face evaluation within one hour.	93	88	91
#5: Results of Physician/Licensed Independent Practitioner's face-to-	88	89	89

face evaluation are documented in the Physician Progress Note.		
#6: Signature within one hour of order.	95	88	92

eclusion Review

	June	July	Mean
N = total number of seclusion events each month	7	2	
n = number of seclusion events audited	7	2	
%S	100	100	
%C			
#4: Physician/Licensed Independent Practitioner conducted a face-to-face evaluation within one hour.	100	100	100
#5: Results of Physician/Licensed Independent Practitioner's face-to-face evaluation are documented in the Physician Progress Note.	100	100	100
#6: Signature within one hour of order.	100	100	100

From my review of 10 individuals who had restraint events (TM, CL, CW, DH, LW, MC, NM, AW, CD, and JC), I found documentation indicating that all 10 were seen within one hour.

In addition, for three individuals who had seclusion events (MC, AW, and

		DH), I found documentation indicating that all were seen by an appropriate practitioner within one hour. **Compliance:** Partial. **Current recommendations**: 1. Continue PMAB training to ensure all direct care nursing staff are competency-based trained on restraints and seclusion. 2. Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Separate and report data regarding PRN, Stat, restraint, and seclusion data entry. **Findings:** MSH has separated data regarding PRN, Stat, restraint, and seclusion data. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** To ensure reliable data regarding PRN and Stat medications, MSH provided an inservice in January 2007 to 96% of the HSSs who are the designated auditors, on scoring the PRN and Stat Medications Monitoring Form and the revised policies regarding PRN and Stat medications. In addition, initial Inter-Rater Reliability tests were conducted among 20% of the Health Services Specialists. The outcome reliability was at 78%. From my discussions with Nursing and Standards Compliance, training needs to continue as well as Inter-Rater Reliability test until an acceptable level

<table>
<tr><td></td><td></td><td>(85% or higher) is achieved. Also see H.2.d.

Compliance:
Partial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>H.5</td><td>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
MSH's A.D. #3306, Behavioral Seclusion or Restraint clearly addresses this requirement. However, the data from MSH and my review indicated that it has not been fully implemented as of yet. From my discussion with Nursing and Standards Compliance, the WRP trainers have been made aware of this issue and will be provided with team-specific data to share with them.

The tables below summarize MSH's compliance data regarding individuals who have been in restraint or seclusion respectively (N) more than three times in a four-week period and review of the WRP within three business days.

Seclusion and Restraint Review
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Mean</th></tr>
<tr><td>N = total number of Individuals each month who have been in seclusion or restraint more than 3 times in a 4-week period</td><td>38</td><td>36</td><td>23</td><td></td></tr>
</table>
</td></tr>
</table>

n = number of audited Individuals who have been in seclusion or restraint more than 3 times in a 4-week period	38	36	23	
%S	100	100	100	
%C #28: If an Individual has been placed in Seclusion or Restraint more than 3 times in a 4-week period, the WRP is reviewed within 3 business days and revised as appropriate.	32	19	78	43

Restraint Review

	June	July	Mean
N = total number of Individuals each month who have been in restraints more than 3 times in a 4-week period	23	36	
n = number of Individuals audited who have been in restraints more than 3 times in a 4-week period	23	36	
%S	100	100	
%C #28: If an Individual has been placed in Seclusion or Restraint more than 3 times in a 4-week period, the WRP is reviewed within 3 business days and revised as	30	33	32

appropriate.		

Seclusion Review

	June	July	Mean
N = total number of Individuals each month who have been in seclusion more than 3 times in a 4-week period	0	2	
n = number of Individuals audited who have been in seclusion more than 3 times in a 4-week period	0	2	
%S	N/A	100	
%C #28: If an Individual has been placed in Seclusion or Restraint more than 3 times in a 4-week period, the WRP is reviewed within 3 business days and revised as appropriate.	N/A	0	0

From my review of five individuals who meet this criterion, CW, NM, CD, AW, and DH, I found no documentation indicating that the WRP was actually reviewed and revised.

Compliance:
Partial.

Current recommendations:
1. Develop and implement a system to ensure compliance with this requirement.
2. Continue to monitor this requirement.

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>H.6</td><td>Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:</td><td>Compliance:
Partial.</td></tr>
<tr><td>H.6.a</td><td>such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:
MSH's Standards Compliance Department sends out PRN and Stat Trigger Reports to Senior Psychiatrists, Program Directors, and Nursing Coordinators. The Wellness and Recovery Teams are to send back responses to activated PRN and Stat triggers to Standards Compliance for integration into the database. From 781 identified PRN and Stat Triggers that were sent to the WRPTs from March through July 2007, 117 (15%) responses were received at Standards Compliance.

The table below summarizes MSH data regarding total Trigger Reports sent to WRPTs (781) and responses received (117) from the WRPTs.

WRT RESPONSES TO ACTIVATED PRN & STAT TRIGGERS BY MONTH
3/1/07 to 7/31/07

Total Responses Sent= 781
<table>
<tr><th>Month</th><th>Key Indicator</th><th>WRT Action</th><th>Description</th><th>Responses Received</th></tr>
<tr><td rowspan="3">3/07</td><td rowspan="3">PRN Medications</td><td>Assessment/ Consultation</td><td>Suicide risk assessment & focused interventions</td><td>2</td></tr>
<tr><td>Behavioral</td><td>Implement DBT</td><td>1</td></tr>
<tr><td></td><td>Individual Psychotherapy</td><td>1</td></tr>
</table>
</td></tr>
</table>

				Environmental	Gradually remove 1:1 observation & replace with another strategy	1	
					Implement alternative treatments	1	
				Medical	Adjust medication regimen	3	
					TRC Consult	1	
			Stat Medications	Assessment/Consultation	Clinical consultation from Senior Clinical Staff	1	
				Medical	Adjust medication regimen	3	
					Neurological Consultation	1	
		4/07	PRN Medications	Assessment/Consultation	Clinical consultation from Senior Clinical Staff	1	
				Behavioral	Develop & implement behavioral guidelines	1	
					Implement DBT	3	
					Individual Psychotherapy	4	
					Skill-Building group	2	
					Teach individual a functionally equivalent & socially acceptable behavior	2	
				Environmental	Modify environmental conditions	2	
				Medical	Adjust medication regimen	4	
					Neurological Consultation	1	
			Stat Medications	Assessment/Consultation	Clinical consultation from Senior Clinical Staff	1	
					Suicide risk assessment & focused interventions	1	
				Behavioral	Individual Psychotherapy	1	
				Medical	Adjust medication regimen	3	
		5/07	PRN Medications	Assessment/Consultation	DCAT team consultation	1	
					Further, focused assessments	1	
				Behavioral	Develop & implement behavioral guidelines	3	
					Individual Psychotherapy	4	
					Skill-Building group	2	
				Environmental	Modify environmental conditions	1	

				Reallocate By-Choice Points	1
			Medical	Adjust medication regimen	12
				ECT Consultation	1
				Other specialty Consultation	1
				Psychopharmacology consultation	2
				TRC Consult	5
6/07	PRN Medications	Assessment/Consultation		Clinical consultation from Senior Clinical Staff	1
				Further, focused assessments	4
			Medical	Adjust medication regimen	8
				TRC Consult	1
7/07	PRN Medications	Assessment/Consultation		Administrative assistance from Program Director	1
				Further, focused assessments	1
			Behavioral	Consultative review from BCC	1
				Implement DBT	3
				Implement PBS plans	1
				Individual Psychotherapy	1
				Skill-Building group	1
			Medical	Adjust medication regimen	13
				Other specialty Consultation	1
				Psychopharmacology consultation	1
				TRC Consult	2
	Stat Medications	Behavioral		Implement DBT	1
			Medical	Adjust medication regimen	1
Total Responses Sent back from WRPTs					117

This monitor would recommend including the number of Triggers sent out per month with this data.

The tables below represent the same data as above but separated by PRN and Stat medications Triggers sent to the WRPTs and the responses sent back from the WRPTs.

PRN Triggers

	March – July 2007
N = total number of identified PRN Medication Triggers sent out to the Wellness and Recovery Teams	546
n = number of PRN Medication Trigger Responses received back at Standards Compliance Dept.	104
%C	19

STAT Triggers

	March – July 2007
N = total number of identified STAT Medication Triggers sent out to the Wellness and Recovery Teams	235
n = number of STAT Medication Trigger Responses received back at Standards Compliance Dept.	13
%C	6

This monitor would again recommend separating the Trigger data by month to identify any trends or patterns and to better evaluate strategies that have impacted compliance rates. Although the Trigger system has not yet been fully implemented, the Standards Compliance data indicated that

		there has been a 51% reduction overall in the use of PRNs and a 37% reduction in the use of Stat medications since September 2006 to July 2007. However, the facility needs to fully implement its PRN and Stat Trigger system to qualify and distinguish the appropriate use of PRN and Stat medications from the inappropriate use of PRN and Stat medications. **Other findings:** A review of five individuals (CL, NM, AW, MC, and CW) was conducted regarding PRN/Stat medications in relation to the individuals' incidents of seclusion/restraints. This monitor's review focused on the nurses' clinical decisions regarding PRN/Stat medication use and the resulting impact on the seclusion/restraints events. CL has been given a number of PRN/Stat medications consisting of Zyprexa and Ativan injections in conjunction with five-point restraints. The documentation in the nurses' notes indicated that she is demanding and attention-seeking. However, there is no indication that staff use any specific therapeutic strategies to address these predictable behaviors. In addition, the documentation indicates that she frequently refuses the oral PRN medications which then leads to the injection, which she clearly prefers. From the documentation, there appears to be no proactive interventions in place. Consequently, the use of the PRN/Stat medications has not reduced the use of restraints. In the case of CW, the documentation indicated that he frequently slaps himself and charges into walls without regard for his own safely. The progress notes indicated that he was placed in restraints on several occasions for these behaviors. However, there was little indication that he was given a PRN/Stat medication to assist him in maintaining control over his impulses and avoid being placed in restraints when he demonstrated an increase in agitation. NM is another individual that the documentation indicated is demanding

		and attention-seeking. There was no indication from the documentation that staff have adequate proactive strategies to deal with her repeating and predictable behaviors. In fact, many of the progress notes indicated a power struggle between her and the staff resulting in an event of restraints and PRN/Stat medications. In the case of AW, she has a history of suicide attempts and had recently swallowed astringent. The documentation indicated that while receiving a Stat injection of Zyprexa, she stated, "Make it hurt," along with other threats to harm herself. From my review, I found no indication that staff work with her when she begins to feel agitated or anxious to proactively take a PRN medication before she loses control and tries to harm herself. Consequently, she has had several events of restraints that appear to be reinforcing her destructive pathology. This monitor's findings are similar for MC regarding the lack of proactive interventions prior to placing her is restraints. The documentation contains no strategies that staff initiated when MC began to become agitated. There is no consistent system in place for her to alert staff when she feels out of control and to take a PRN medication to possible avoid the use of restraints. This monitor did find one progress note that indicated that she was offered a PRN of Vistaril which she took; she was able to maintain control and her subsequent behavior did not warrant the use of restraints. **Current recommendations**: 1. Implement the PRN and Stat Trigger System. 2. Provide Trigger data by month. 3. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
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Recommendation, March 2007:
Same as above.

Findings:
The table below summarizes MSH's compliance data regarding specific and individualized rationale for PRNs for the individuals at the facility (N).

Psychiatry Monthly Progress Notes
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of Individuals in the hospital</td><td>549</td><td>557</td><td>554</td><td>560</td><td>590</td><td></td></tr>
<tr><td>n</td><td>54</td><td>68</td><td>47</td><td>41</td><td>33</td><td></td></tr>
<tr><td>%S</td><td>10</td><td>12</td><td>8</td><td>7</td><td>6</td><td></td></tr>
<tr><td>%C
#13 Rationale for PRN medications and review of rationale for ongoing PRN medications used.</td><td>74</td><td>75</td><td>72</td><td>68</td><td>64</td><td>72</td></tr>
</table>

Upon review of 13 individuals who have received PRN medications (TM, CL, CW, DH, LW, MC, NM, AW, CD, JC, MC, AW, and DH), this monitor found that only one individual's (CW) PRN order was specific to his behaviors. However, the other 12 individuals' PRN orders included generic behaviors such as agitation rather than specific and individualized behaviors.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>H.6.c</td>
<td>PRN medications are appropriately time limited.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2007:
Same as above.
</td>
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</table>

<table>
<tr>
<td></td>
<td></td>
<td>Findings:
To address this requirement, MSH is considering a 14-day time limit on psychotropic PRN medications to ensure adequate physician review. This issue was discussed at the June 2007 Medical Executive Committee meeting and is awaiting final approval. Once finalized and implemented, monitoring this issue will be done through the Medication Variance Reporting System.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>H.6.d</td>
<td>nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Continue to monitor this requirement.

Findings:

PRN Medications Monitoring Form
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>N = total number of PRNs administered each month</td><td>689</td><td>772</td><td>840</td><td>615</td><td>669</td><td></td></tr>
<tr><td>n = number of PRN medications audited</td><td>231</td><td>225</td><td>186</td><td>195</td><td>193</td><td></td></tr>
<tr><td>%S</td><td>34</td><td>29</td><td>22</td><td>32</td><td>29</td><td></td></tr>
<tr><td>%C</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>#4: Nursing staff assesses the Individual within one hour of the administration of the psychiatric PRN</td><td>73</td><td>75</td><td>64</td><td>75</td><td>73</td><td>72</td></tr>
</table>
</td>
</tr>
</table>

		medication. | | | | | | | #5: Nursing staff documents the Individual's response to PRN medication. | 63 | 57 | 55 | 59 | 66 | 60 | **Stat Medications Monitoring Form** | | Mar | Apr | May | Jun | Jul | Mean | N = total number of STATs administered each month | 261 | 143 | 167 | 187 | 206 | | n = number of STAT medications audited | 108 | 69 | 63 | 58 | 74 | | %S | 41 | 48 | 38 | 31 | 36 | | %C | | | | | | | #4: Nursing staff assesses the Individual within one hour of the administration of the psychiatric Stat medication. | 66 | 72 | 75 | 76 | 77 | 73 | #5: Nursing staff documents the Individual's response to Stat medication. | 60 | 60 | 59 | 64 | 64 | 61 | **Current recommendation**: Continue to monitor this requirement.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as	**Current findings on previous recommendation:** **Recommendation, March 2007:** Same as H.6.a.

	appropriate, adjustment of current treatment and/or diagnosis.	**Findings:** Same as in D.1.f, F.1.b and H.6.a. **Compliance:** Partial. **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue the development and implementation of a monitoring instrument to accurately monitor this requirement. **Findings:** See H.3, F.3.h.i, and F.3.i **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** MSH provided training regarding PRN/Stat Medications to 44% of the level of care nursing staff in January and February 2007. Additional training was provided in May, June, and July 2007 with an 84% training attendance. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.

H.8	Each State hospital shall:	**Compliance:** Partial.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety. **Findings:** MSH has drafted a Falls Committee Charter in March 2007 with an overall mission of overseeing the MSH hospital-wide Fall Reduction Program. The Falls Committee, co-chaired by a Physician and a Registered Nurse, initially met on June 13, 2007. The Committee has developed a draft of an Administrative Directive on Falls Prevention/Management Program. After additional review, the draft will be finalized. In addition, a monitoring tool has been developed to track the use of Side Rails and Other Device/Equipment (soft ties and other medical restraints). In March 2007, baseline data were collected on individuals who are currently using Side Rails and Other Devices. **Recommendation 2, March 2007:** Develop and implement a system to monitor, track, and reduce, if appropriate, the use of soft tie and other medical restraints. **Findings:** MSH has revised the monitoring instrument for Use of Side Rails and Other Device/Equipment in alignment with the EP in May 2007. Input and feedback from the SNF Senior Psychiatrist, Psychiatrists, and Medical Consultants were utilized in drafting the monitoring instrument. Further approval from the Medical Executive Committee is pending before this instrument can be implemented. The Standards Compliance Department will integrate the data from this instrument into a computer database.

		Recommendation 3, March 2007: Continue to monitor this requirement. **Findings:** See data in H.8.b **Other findings:** In an attempt to decrease the use of side rails, it appears that MSH has decreased a number of full side rails to half side rails without adequate justification. For example, LB has required full side rails. However, they were decreased to half side rails on 8/17/07 without an assessment of the risks. Consequently, he was found on the floor on 8/24/07. **Current recommendations:** 1. Continue to implement the system to monitor this requirement. 2. Ensure adequate assessments are completed to justify decisions regarding side rail use. 3. Continue to monitor this requirement.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Implement the monitoring instrument addressing this requirement. **Findings:** See H.8.a. **Recommendation 2, March 2007:** Continue to monitor this requirement. **Findings:** The following table summarizes MSH's data regarding individuals who use

side rails (N) and the items listed on the table:

Use of Side Rails and Other Device/Equipment Monitoring Form

	Mar	Apr	May	Jun	Jul	Mean
N = total number of Individuals using side rails and other device	x	x	15	15	15	
N = number of audited Individuals using side rails and other device	x	x	10	10	5	
%S	x	x	67	67	33	
%C						
#1: There is a Physician's Order for the use of side rail and/or other device/equipment.	x	x	100	100	100	100
#2: The Physician's Order includes clinical justification and duration of use.	x	x	70	80	100	83
#3: There is an RN Assessment in the IDN addressing the use of side rail and/or other device/equipment with every Physician's initial or renewal order.	x	x	0	10	0	30
#4: There is documentation in the Daily Care Flow Sheet (MSH 1152) for use of side rail and chair that prevents rising.	x	x	70	70	100	80
#5: There is documentation in the Physical Restraint	x	x	70	70	80	73

		Observation Sheet (MSH/SNF 1201b) for use of trunk restraint, limb restraint, and mittens.						
		#6: There is documentation in the Nursing Weekly Summary and Nursing Monthly Summary.	x	x	30	40	20	30
		#7a: The WRP expressly addresses the use of side rails and/or other device/ equipment,	x	x	80	80	60	73
		#7b: including identification of the medical symptoms that warrant the use of side rails and/or other device/equipment,	x	x	80	80	100	87
		#7c: methods to address the underlying causes of such medical symptoms,	x	x	80	80	100	87
		#7d: and strategies to reduce the use of side rails and/or other device/equipment, if appropriate.	x	x	60	60	60	60
		In the charts of 13 individuals who use side rails (GB, JP, RM, KG, EL, DE, LB, DC, TP, JP, EG, HN, HF), all had physician orders for side rails. However, this monitor found the no documentation in the nurses' notes that an assessment was conducted regarding side rails and inconsistent documentation in the weekly and monthly nursing summaries. In addition, this monitor found four WRPs that mentioned the use of side rails (LB, DC, EG, HN). However, none of the 13 WRPs addressed strategies to reduce							

		the use of side rails. **Other findings:** The use of other devices such as soft tie restraints and Broda/Geri chairs need to be monitored and addressed as restraint devices. **Current recommendations**: 1. Continue to monitor this requirement. 2. Separate other restraint devices in the data.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. MSH has begun producing reports showing trends and patterns using incident and trigger data. 2. MSH has a forum for the review of this data by senior managers in the Performance Improvement Committee. 3. The Special Investigators and officers working in the Office of Special Investigations have received Incident Management training. The hospital plans to have all of the Incident Management training completed (including Unit Supervisors) by the spring of 2008. 4. Investigation reports use a standard format that covers all essential information. 5. The review of investigation reports by senior hospital administrators has improved substantially. These reviews now identify programmatic recommendations for improvement and problems in the conduct of the investigations. 6. MSH is consistent in reassigning staff alleged to have engaged in serious misconduct to work that does not involve contact with individuals until the investigation is complete. 7. MSH has implemented a procedure involving senior administrators to review incidents and determine whether under certain circumstances a staff member can be allowed to work on the unit while the investigation is ongoing. 8. The Human Resource Department is doing an excellent job of collecting recommendations made by various administrators during the incident review process, communicating them clearly in writing to the unit and requesting a response by a particular date. 9. The hospital alerts units when an individual has reached a trigger. Trigger meetings to determine and document the team's response are held weekly. 10. The hospital has implemented a procedure that has the capacity to track the response of units when an individual has reached a

		trigger. 11. Environmental hazards have been prioritized, work is continuing, and the facility is tracking progress.
1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. C. Lusch, Clinical Administrator 2. D. Bates, Human Resource Director 3. H. Mears, Chief of Hospital Police 4. M. Nunley, Standards Compliance Director 5. W. Amberry, Senior Special Investigator 6. B. Hudson, Special Investigator 7. L. Dieckman, Standards Compliance Psychologist 8. L. Scott, Program Assistant, Program 5 9. M. McNeil, Standards Compliance Reviewed: 1. Mortality Review Committee minutes for 2007. 2. 16 investigations completed by the Office of Special Investigations 3. Office of Special Investigations review of two deaths 4. 12 Special Incident Reports 5. Investigation Compliance Monitoring Data 6. Investigation Recommendation Follow-up Monitoring Data 7. Relevant sections of the personnel records for 12 staff members 8. Aggregate incident and investigation data 9. Incident pattern reports 10. Records of 12 individuals (for rights acknowledgement forms.)
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management	**Compliance:** Partial.

	policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue new employee orientation using the new curriculum. **Findings:** The practice of using the newer curriculum for abuse and neglect training during orientation has continued. **Recommendation 2, March 2007:** Ensure that the training on abuse and neglect and the training on the use of behavior management techniques stresses that the misuse of restraint and seclusion is abuse and will be treated as such. **Findings:** This recommendation has been implemented. The abuse and neglect training includes the review of abuse definitions. The misuse of restraints is specifically identified as a form of abuse in the newly revised Serious Incident Report (SIR) definitions. **Recommendation 3, March 2007:** Conduct unannounced reviews of unit documents (logs, calls to physicians and police, etc.) looking for under-reporting of incidents. Document the conduct of these reviews. **Findings:** This recommendation has not been implemented.

		Other findings: No incidents of alleged neglect were reported during the six-month period since the last visit. **Current recommendations**: 1. Look for evidence of under-reporting 2. Review training materials and ensure that neglect, as it would likely occur in the hospital setting (as contrasted with familial neglect), is adequately covered, along with the responsibility to report.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue the work of the statewide group revising incident management definitions for the four hospitals. **Findings:** The newly revised SIR definitions have been approved, published and are now in use. **Recommendation 2, March 2007:** Continue the careful review and correction, as necessary, of the SIRs. **Findings:** Problems in the coding of the type of incident and injury level were evident in four SIRs from a sample of nine for incidents involving injuries that did not involve allegations of abuse or neglect. If this sample is representative, there remains a problem in the completion and review of SIRs .

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<tr><td>SIR (numbers removed for confidentiality purposes)</td><td>Problem</td></tr>
<tr><td>A</td><td>SIR narrative and expanded Level 2 review focus on self harm. SIR is coded physical aggression to peer. Lists another individual as the aggressor, who is not mentioned in the narrative as the aggressor. Fails to code main individual's injury.</td></tr>
<tr><td>B</td><td>Individual complained of pain. Foreign body felt through abdominal wall. SIR coded "Medical Intervention" rather than self-harm.</td></tr>
<tr><td>C</td><td>Victim of aggression was sent to community hospital ER for evaluation and treatment. Injury was coded as "minor first aid."</td></tr>
<tr><td>D</td><td>Injury (deep laceration on thumb from breaking a window) is coded both S2 and S3.</td></tr>
</table>

Current recommendation:
Initiate close review of SIRs on the unit level and continue the review as SIRs are processed and information entered into databases.
</td>
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<tr>
<td>I.1.a.iii</td>
<td>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Continue the practice of moving staff to non-individual contact positions during investigations of allegations of physical, psychological, and sexual abuse and neglect.

Findings:
MSH routinely removes staff members alleged to have engaged in misconduct to positions where they will have no contact with individuals</td>
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		in care or places them on administrative leave when a credible allegation has been made. Several of the investigation reports reviewed confirmed that this practice continues. For example, at the conclusion of the 4/16/07 allegation of sexual abuse made by GR, the named staff member was allowed to return to work following the close of the investigation on 7/5/07. Similarly, in the substantiated physical abuse case involving NM that occurred on 2/10/07, the named staff member was placed on administrative leave. She resigned at the conclusion of the investigation. **Recommendation 2, March 2007:** Weigh the risks and benefits of removing staff members from units when the allegation is verbal abuse. For example, in those instances of alleged verbal abuse where the staff member has an excellent work history, there are no witnesses to the verbal abuse (individuals as well as staff) or other evidence immediately available to support the allegation, the decision might be made to allow the employee to work on his/her unit, but always under supervision, until the investigation is completed. **Findings:** MSH has recently instituted an Incident Management Review process composed of the Executive Director, Clinical and Hospital Administrators, Chief of Police, Human Resources Director, Medical Director and the Coordinator of Nursing Services that determines whether a staff member can be put back to work, under supervision, pending the outcome of an investigation. **Recommendation 3, March 2007:** Provide the necessary clinical interventions through the WRP to those individuals who have a history of making false allegations and monitor the effectiveness of the interventions.

		Findings: The review of WRPs of five individuals identified as having made false allegations revealed that this problem was not identified for any of the five. These individuals include KR (Unit 412), CK and CD (Unit 414) and MW and PL (Unit 416). MSH's review of 49 individuals identified as having a history of making false allegations revealed that 35% had this behavior identified in a focus and had interventions in place. In all of the investigations and SIRs reviewed, individuals who sustained an injury or might have sustained an injury based on the circumstances of the incident were seen by health care personnel, unless they refused evaluation and treatment. **Current recommendation**: Provide the necessary clinical interventions in the WRP to those individuals identified as having a history of making false allegations and monitor the effectiveness of treatment.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to implement the expanded training. See also the recommendation in I.1.a.i regarding the misuse of restraint and seclusion. **Findings:** The misuse of restraint and seclusion is specifically identified in the SIR definitions as a form of abuse. This is taught in the Incident Management training.

		Other findings: In a review of the training records of 11 staff members, ten were in compliance with current training expectations for annual refresher abuse/neglect training scheduled around the time of their birthday month. Six staff members whose birthdays in 2007 had passed had taken annual refresher training, four staff members had autumn birthdays, and one staff member whose birthday occurred in February had not taken refresher training, although another staff member who also had a February birthday had completed the training, indicating the refresher training was being offered that early in the year. There was inconsistency among the sample of staff who had completed training in the type and length of the training. Two staff watched a 30-minute video, one staff watched a one-hour video, one staff had one-hour live instruction and one had 1.5 hours live instruction, according to the training records. [The sixth staff member had four-hour Supervisor Incident Management Training.] **Current recommendation**: Standardize the instruction for classifications of staff members, both in what is offered and how it is recorded on the training records.
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue work on identifying staff members who have not acknowledged their mandatory reporting responsibilities in writing. **Findings:** This work has continued. See below under Other Findings. **Recommendation 2, March 2007:** In the annual abuse/neglect training, include reminders to staff that

		they have signed this form acknowledging their responsibility to report dependent adult and child abuse. **Findings:** This recommendation has been implemented and staff are reminded of their responsibilities as mandated reporters. **Recommendation 3, March 2007:** Emphasize the need to complete both a SIR and a SOC 341 form when there is an allegation of abuse. **Findings:** The responsibility to complete both a SIR and a SOC 341 form is addressed in the abuse and neglect training during orientation and at the annual training. **Recommendation 4, March 2007:** Ensure that both of these forms are available on all units. **Findings:** During the tour, staff were able to show me a supply of SIR forms on each of the six units. On two of the units, the SOC 341 forms were kept in the Unit Supervisor's office. **Other findings:** The investigation reports reviewed indicated that in some instances there is still a problem in ensuring that a SOC 341 form is completed when there is an allegation of dependent adult or child abuse. For example, in the 12/23/06 incident involving JC and in the 5/5/07 incident involving MW, the investigation reports specifically note the failure to complete an SOC 341 form. A review of the relevant sections of the personnel records of 12 staff

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<td>members for evidence of signed acknowledgement of mandatory reporter obligations revealed that all have signed the acknowledgements for both child abuse and dependent adult abuse reporting. The records of three staff indicated that they were identified in the recent reviews as missing an acknowledgement. These were signed on 6/27/07, 9/6/06 and 3/1/07.

MSH data indicates that only 10 staff members have not signed both mandatory reporting forms.

Current recommendation:
Identify a system that will ensure that an SOC 341 is completed when there is an abuse allegation. Perhaps CNS could remind the caller of the need to complete this form when the caller is requesting an SIR number for an abuse allegation.</td>
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<td>I.1.a.vi</td>
<td>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</td>
<td>Current findings on previous recommendation:

Recommendation, March 2007:
Spot-check compliance with the new Administrative Directive for annual signing of the rights statement.

Findings:
Although the Administrative Directive requiring that rights of individuals be reviewed with them annually became effective in March 2007, implementation was delayed.

Other findings:
A review of the records of 12 individuals yielded the following results.

<table>
<tr><th>Individual's initials</th><th>Most recent signing of rights acknowledgement</th></tr>
<tr><td>CK</td><td>5/12/04</td></tr>
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		<table><tr><td>CD</td><td>1/11/06</td></tr><tr><td>VF</td><td>12/22/06*</td></tr><tr><td>MW</td><td>5/3/05</td></tr><tr><td>WP</td><td>Refused, 7/20/06*</td></tr><tr><td>ST</td><td>Not in record</td></tr><tr><td>GA</td><td>6/19/01</td></tr><tr><td>SR</td><td>11/29/01</td></tr><tr><td>TR</td><td>11/18/03</td></tr><tr><td>KR</td><td>7/1/05</td></tr><tr><td>GB</td><td>2/21/06</td></tr><tr><td>JS</td><td>3/7/04</td></tr><tr><td>EB</td><td>Not in record</td></tr></table> *=date of admission These monitoring results are consistent with the hospital's internal audit of 11 records of individual's whose Annual Review occurred in July. The hospital found that none of the 11 individuals had signed the advisement form at the time of their annual review. **Current recommendation**: Ensure the AD 3350.1 entitled Notification of Patients' Rights has been published/disseminated and spot-check compliance.
I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** On all units visited, the Rights poster was displayed. **Other findings:**

		Presently, there is no Patients' Rights Advocate (PRA) at the hospital. Individuals can still file complaints, which are accepted and passed on to the Program Director by the Administrative Assistant in the PRA office. On all units visited, staff were able to quickly locate a supply of blank forms for making a complaint to the PRA. **Current recommendations:** 1. Include the name of the PRA on the posters when one is hired. 2. Question individuals (perhaps at the Individuals' Council or Senate) to ensure that they are receiving a response to their complaints from the PRA office and program leaders during this interim period when there is no PRA.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Work to ensure that incidents that require investigation are forwarded to the hospital police and Special Investigator promptly. **Findings:** The failure to move incidents along so that the Office of Special Investigations receives them in a timely manner remains a very serious problem that contributes to the failure of the investigations to meet professional standards. **Other findings:** A review of 14 investigation reports completed by the Office of Special Investigations reveals substantial delays in notifications being made to the Hospital Police (HP)/Special Investigations in five cases as follows:

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<table>
<tr><th>Individual's Initials</th><th>Date Incident Reported</th><th>Date received by HP</th></tr>
<tr><td>JG</td><td>2/4/07</td><td>2/23/07</td></tr>
<tr><td>MW</td><td>5/5/07</td><td>5/25/07</td></tr>
<tr><td>RP</td><td>1/30/07</td><td>2/23/07</td></tr>
<tr><td>SF</td><td>8/30/06</td><td>1/7/07</td></tr>
<tr><td>RD</td><td>1/11/07</td><td>2/14/07</td></tr>
</table>

Current recommendation:
Identify and correct the problem that is causing delays in incidents reaching the attention of hospital police for several weeks or more in some cases.</td></tr>
<tr><td>I.1.a.ix</td><td>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</td><td>Current findings on previous recommendation:

Recommendation, March 2007:
Complete an SIR and an investigation whenever an individual or staff person reports threats of or actual retaliatory action for reporting an allegation.

Findings:
A single incident related to retaliation was reported on 6/6/07 when a staff member threatened to kill peers. This was investigated and the staff member placed on administrative leave. She later resigned before she could be terminated.

Current recommendation:
Continue current practice of opening an investigation when there is an allegation of retaliation or threat of retaliation.</td></tr>
<tr><td>I.1.b</td><td>Each State hospital shall review, revise, as appropriate, and implement policies and procedures</td><td>Compliance:
Partial.</td></tr>
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	to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue work on the training initiatives for hospital police and the investigation training for administrators and program and unit supervisors. **Findings:** The Chief of Police reported that the Special Investigators and the four officers who are working for his office have completed the Incident Management training. Ten Hospital Police will be trained each month. Administrators and supervisors (including Unit Supervisors) will be trained as well. All training will be completed by April 2008. **Recommendation 2, March 2007:** Avoid ambiguous language, including the use of passive voice, in the Mortality Review Committee minutes. **Findings:** I found no evidence of passive voice and other ambiguous language in the 2007 Mortality Review Committee minutes. **Recommendation 3, March 2007:** Pursue information and personnel necessary to complete a death review and track this through completion in the minutes. **Findings:** The physician who was treating the decedent was invited to and attended the Mortality Review Committee where the individual's death

		was discussed. **Recommendation 4, March 2007:** Review the death summaries from the Medical Director's office to see if reformatting would increase the pertinent information presented. **Findings:** The format for these summaries remains the same, with the majority of the information still relating to the individual's past psychiatric and criminal history and current diagnoses. **Recommendation 5, March 2007:** Continue to pursue avenues for making hospice services available to individuals in care. **Findings:** The hospital is drafting a Hospice Referral form to be completed by the Health Care Practitioner and forwarded to Medical Services when an individual requires hospice services. **Recommendation 6, March 2007:** Work on ensuring timely notification to the hospital police and Office of Special Investigations of incidents that require investigation. **Findings:** See I.1.a.viii **Other findings:** Incidents of serious injury are investigated by the individual's program. The staff involved in these investigations are being trained in the conduct and review of investigations. Some incidents reviewed included expanded Level 2 reviews, which

		more clearly stated the individual's present status and corrective actions planned or implemented and which have avoided being merely a reiteration of the circumstances of the incident. The incident involving TP on 3/14/07 is an example of an expanded review (although there are problems in the SIR that were not identified). The investigation of the death of TC (9/11/06) by the Office of Special Investigations raised several questions. First, the report states that a psychiatric technician "tried to intubate" the decedent while a physician looked on. Given that a physician was present, it is surprising that a psychiatric technician would have conducted the procedure. This may be a misstatement of what occurred that was not caught on review and in any event needs to be followed up on. Second, the psychiatric technician stated that the ambu bag was cracked and did not create a tight seal, but there was no subsequent recommendation to inspect all ambu bags hospital-wide for similar defects. **Current recommendations:** 1. Identify a procedure whereby serious injuries are investigated by trained staff members who have no reporting obligations to the program or elements of the facility associated with the allegation. 2. Ensure that the Office of the Medical Director and the Coordinator of Nursing Services closely read the Special Investigations of deaths for accuracy and to identify any corrective actions needed.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Move forward with the initiative to provide hospital police increased training.

		Findings: This recommendation is being implemented. Ten hospital police are being trained using the Incident Management curriculum each month. **Recommendation 2, March 2007:** Continue to encourage programs to complete SIRs appropriately and do not accept SIRs that are not completed accurately. **Findings:** Incomplete and inaccurate SIRs remain a problem. See the findings reported in Section I.1.a.ii. **Other findings:** One SIR coding issue needs clarification. In those incidents that involve a suicide or suicide attempt, staff code the individual variously as the "victim", "involved" or "aggressor." **Current recommendations**: 1. Clarify the correct coding for an individual who has completed or attempted suicide. 2. Require programs to review SIRs for completeness and accuracy and communicate promptly with units about deficient SIRs to ensure their correction.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** I saw no evidence of the failure to safeguard evidence in any of the investigation reports I reviewed. This finding is consistent with the

		hospital's own Investigation Monitoring and with the hospital's self-assessment. **Current recommendation:** Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendations:** **Note: The MSH data cited in the succeeding cells is from the data sheet titled "Investigations" which used a 100% sample.** **Recommendation 1, March 2007:** Create a face sheet for investigation reports that includes the date closed, the names/titles of persons interviewed and the disposition in addition to the information already provided on the face sheet. **Findings:** This face sheet has been developed and is being used in investigations completed by the Office of Special Investigations. **Recommendation 2, March 2007:** Add to the Investigation Compliance Monitoring Form an item that asks if the rationale for the disposition addresses the relevant sections of the definition of the allegation under review as presented in Special Order 227.07. **Findings:** This recommendation has not been implemented. **Recommendation 3, March 2007:** Indicate on the Investigation Compliance Monitoring Form when the "N" for an item differs from that indicated for the month.

		Findings: This recommendation has been implemented. Data produced by Standards Compliance makes clear when NAs (not applicable) are influencing the data. **Recommendation 4, March 2007:** See also the recommendations in other cells that would improve the quality of investigations. **Findings:** Investigations are marred principally by lack of timeliness, failure to attempt to reconcile conflicting evidence, and inadequate rationales for determinations. **Other findings:** Presently, the Investigation Compliance Monitoring form is not used within the Office of Special Investigations as a tool for the supervision of investigations. Thus, investigators may not be familiar with the criteria upon which their work is being judged. **Current recommendations**: 1. The Chief of Police will review the monitoring form with the Special Investigators and officers completing investigations, so that they will understand the criteria used to evaluate their work. 2. The Chief of Police will complete the monitoring form at the close of each investigation as he reviews it for completeness and accuracy. This is not to impinge on the work of Standards Compliance in this area.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Hire the two additional Special Investigators as quickly as possible.

Findings:
The two Special Investigators that were expected to be hired, have not been hired as of yet. DMH Central Office is taking steps to expedite filling Special Investigator positions at MSH and the other hospitals by clearing the hiring of retired annuitants.

Recommendation 2, March 2007:
Interview all relevant parties while their recollections of the incident are fresh.

Findings:
The timely interviewing of relevant parties is seriously impaired by two factors: the late notification to the Hospital Police of abuse/neglect allegations and the late assignment of an investigator to the case.

Other findings:
In the review of 14 abuse investigations, the untimely assignment of the case to an investigator was a factor in the failure of nine cases to meet professional standards.

Individual's initials	Date Incident reported	Police Notified	Assigned to Special Investigator
FJ	1/22/07	1/23/07	4/11/07
SF	8/30/06	1/7/07	4/11/07
JS	2/8/07	2/14/07	5/3/07
JC	12/23/06	12/29/06	3/23/07
MW	5/5/07	5/25/07	6/21/07
NM	2/10/07	2/14/07	5/17/07
NM	2/14/07	2/22/07	6/10/07
JA	1/7/07	1/8/07	3/28/07
RD	1/11'07	2/14/07	4/21/07

		An explanation offered for the delay in assigning cases to investigators related to the goal of ensuring that a case, once assigned, would be worked quickly before another was assigned. Looking critically at the workload of the Special Investigators and the officers also working for the Office, one questions why more investigations were not completed. MSH has two Special Investigators working full-time and four officers who have other duties as well—all under the direction of the Chief of Police. Assuming this configuration equals 3.5 full-time equivalent (FTE) investigators, each FTE completed nine investigations over the six-month period March through August 2007 or 1.5 investigations per month. [Office of Special Investigations data indicates that nine investigations were completed in March, three each in April and May, four in June, five in July and nine in August.] **Other findings:** Hospital data indicates that 20% of the investigations completed by the Office of Special Investigations were begun within 24 hours of the reporting of the incident during the May through August 2007, with no investigations reaching this goal in August. This is consistent with my findings. **Current recommendation**: Revise supervision of the Special Investigators so that investigators meet with supervisors to review progress on cases at least bi-weekly. Provide mentoring and assistance as necessary. Use the Investigation Compliance Monitoring form as a training and supervision tool.
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop a tickler system to alert investigators to renew the request for the autopsy periodically or to ask for assistance when his/her efforts have not been successful.

		Findings: The investigation report of the death of JC stated that the autopsy was received four month after the death. Date of death = 9/11/06, date autopsy received = 1/16/07. **Recommendation 2, March 2007:** Avoid spreading interviews over several months if at all possible. When this cannot be avoided, provide the reason for the delays in conducting interviews. **Findings:** Interviews conducted weeks and months after an incident were common in the investigation reports reviewed. This is due, in some measure, to the work distribution patterns already discussed, i.e., failure of timely notification of incidents to the hospital police and delays in assigning cases to investigators. The delay in interviewing relevant parties is severely compromising the integrity of the investigations. **Other findings:** In two cases reviewed, the alleged victim could not be interviewed because he had been discharged by the time the case was opened. [Incident involving JS on 2/3/07 assigned on 5/3/07 and incident involving MW on 5/5/07 and assigned on 6/21/07.] In a child abuse case, the child victim could not remember the incident when she was interviewed nearly four months after the incident occurred. [Date of incident=1/10/07, date of interview=4/27/07.] In a second child abuse case, the incident occurred on August 25, 2006, but the victim and the alleged perpetrator were not interviewed until the following April.

		MSH data indicates that 19% of the SI cases during the period May through August were completed within 30 days. **Current recommendation**: Change the procedures for assigning and supervising investigations in order to identify the source of the tardiness problems and take corrective actions.
I.1.b.iv.3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	**Current findings on previous recommendation:** **Recommendation, March 2007:** Conclude all investigations with a statement of facts that supports the disposition determination and specifically addresses the elements of the abuse definition and whether the evidence standard has been reached. **Findings:** Some investigation reports reviewed followed this recommendation and specifically cited the abuse definition, as was the case in the substantiated case of psychological abuse of NM. **Other findings:** A February 2007 allegation of verbal abuse involving FR was determined unsubstantiated, although a staff witnessed the verbal abuse. In conversation, I learned that this determination was made because the staff member was determined to be unreliable. There was no reference in the report findings or in the rationale for the determination of the unreliability of the staff member. Thus, the determination had no basis in fact as presented in the investigation report. All investigation reports reviewed resulted in written reports. Specific areas of shortcomings are discussed in the cells below.

		Current recommendations: 1. Continue the use of the face sheet to provide critical information up front. 2. Discourage the practice of completing the summary section of the investigation by cutting and pasting large sections of interviews. The summary should include only the salient points that must be considered in making a determination. 3. Place all findings that support a determination in the body of the report. This is not to suggest that conflicting evidence should not also be presented.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Include in any investigation training the requirement to file an SIR on any allegation of retaliation for reporting abuse and neglect. **Findings:** The orientation training and the annual abuse/neglect training instruct staff in their responsibility to file an SIR for any allegation of retaliation for reporting. **Recommendation 2, March 2007:** In the review of investigations and other documents, look for statements from individuals that suggest or reference threats of retaliation and ensure they have been investigated. **Findings:** A separate investigation was opened on a staff member who made a credible threat to kill staff members in a particular program after she was found to have physically abused an individual in that program. The staff member resigned prior to being terminated.

		Current recommendation: Continue current practice.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop a method for identifying off-unit staff members who participate in physical interventions so that this information can be available to investigators if it is needed later. **Findings:** This recommendation has been implemented. Staff members who come to another unit to assist in a crisis sign in on the unit log. **Recommendation 2, March 2007:** Document attempts to find individuals who may be witnesses to incidents. **Findings:** One of the 14 investigations reviewed contained specific information that no witnesses were present. This is the case in the 1/23/07 incident involving RP. In other instances, there is no mention of an attempt to find other witnesses. Such attempts would have been impaired by the delayed start of the investigation. **Current recommendations**: 1. Train hospital police officers to gather information on witnesses (including individuals as well as staff) when they are called to the scene of an incident. 2. Start Special Investigations in a timely manner.

I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** All written investigation reports and SIRs reviewed included the name of the alleged victim and the name and work title of the alleged perpetrator. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Include the name and title/position of all persons interviewed on the face sheet of the investigation. **Findings:** All persons interviewed during the investigation are clearly identified in the written report by name and title. The date and location of the interview is also clearly identified. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Attribute all statements to the source.

		Findings: I found no instances in the investigations reviewed where the source of statements and information was not identified. **Recommendation 2, March 2007:** Identify hearsay evidence. **Findings:** I found no instances of hearsay evidence in the investigation reports reviewed. **Other findings:** All investigation reports reviewed contained a summary of each interview. Interviews generally started with open-ended questions, as standard practice would dictate. Interviews were less successful in following up with specific questions that would nail down ambiguous answers or help to clarify conflicting evidence. **Current recommendation**: Move beyond a free narrative of events and ask pointed questions that will help to highlight conflicting evidence and explain the disparities.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue current practice. **Findings:** In all investigation reports reviewed, documents reviewed during the course of the investigation were listed at the conclusion of the report. In the investigation report of the death of MG, the investigator did a particularly good job of synopsizing the relevant events leading up to the suicide.

		Current recommendation: Continue current practice.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to work on providing investigators access to the incident history of individuals and staff members. This information should include at a minimum the date, location, type of allegation, and the disposition. **Findings:** Investigators have access to information about a staff member's incident history from Standards Compliance and information about his/her disciplinary history from Human Resources (HR). Review of the 14 investigations revealed variable compliance with the requirement to review a staff member's incident and disciplinary history. For example, the investigator did not review the discipline history for the named staff member in the 1/22/06 incident involving MC. The history would have been informative. In the 12/23/06 involving JC, the investigator reviewed the disciplinary history of one of the two named staff members. The disciplinary history of a long-term employee was reviewed in the investigation of the 2/14/07 incident involving NM. **Recommendation 2, March 2007:** When necessary, review a staff member's incident history not only for the number of incidents he/she was involved in, but also for the type of incident to look for similarities in circumstances, language used, etc. **Findings:** I have no evidence that this recommendation has been implemented.

		Other findings: MSH data indicates that in 58% of the special investigations, the incident histories of the staff member and the individual were reviewed. This is not consistent with my findings. **Current recommendation:** Review investigations during supervision to ensure that both sources of information (incident history and discipline history) are reviewed and documented.
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Write a complete and concise summary of findings that supports the determination and addresses the elements of the abuse allegation and how the findings meet the standard of evidence. **Findings:** This recommendation is not being implemented satisfactorily. In some investigations, the incident definition is being cited. This is the case, for example, in the investigations of the 2/14/07 incident involving NM (psychological abuse) and the 2/10/07 incident involving NM (physical abuse). [These incidents do not involve the same individual.] This represents an improvement over previous performance. Investigation reports commonly provide a statement of the allegation and a summary of the interviews and conclude with a statement that reads, "Based on the statements and evidence secured during my investigation, the allegation of ___ is ____ (substantiated or unfounded.)" There is no indication which bits of evidence the investigator was using to support the determination and why that evidence was more convincing than the conflicting information.

		Other findings: The investigations reviewed showed substantial improvement in the hospital's identification of findings related to staff's failure to follow hospital policies that do not rise to the level of abuse and neglect. For example, in the 11/22/06 incident involving MC, the investigation found violations of hospital policy in the failure to notify hospital police. The investigation of the 12/23/06 incident involving JC resulted in a finding that the use of the blanket to prevent spitting did not constitute abuse, but did violate hospital policy and the staff member was counseled. The investigation of the 1/22/07 incident involving FJ resulted in the identification of the unsafe practice of assigning a single staff member to escort 30 individuals to a Mall group. As investigations are reviewed by the Program Director, Medical Director, Clinical Hospital Administrator, Executive Director etc., these reviewers are identifying problems in the handling of the investigations as well as programmatic corrective actions. **Current recommendations**: 1. Continue the current practice of painstakingly reviewing the investigation reports, identifying needed corrective measures and deficiencies in the investigation process. 2. Revise summary statements to support the determinations made, citing specific information and addressing conflicting information.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Do not spread interviews over several months unless there are extenuating circumstances, which should be described in the investigation report.

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<td>Findings:
Interviews weeks and months after the event continue to compromise investigations. A sample of the problem includes the following:

<table>
<tr><td>Date of Incident</td><td>Date of First Interview</td></tr>
<tr><td>12/23/06</td><td>3/26/07</td></tr>
<tr><td>5/5/07</td><td>6/23/07</td></tr>
<tr><td>2/10/07</td><td>5/18/07</td></tr>
<tr><td>2/14/07</td><td>6/20/07</td></tr>
<tr><td>1/10/07</td><td>4/27/07</td></tr>
</table>

Other findings:
As described in I.1.b.iv.3(viii), summary statements do not identify the specific basis for the determination in many of the investigations reviewed. There was no evidence in the investigation reports reviewed that the investigator had done second interviews or in some other manner attempted to reconcile conflicting evidence.

MSH data indicates that 80% of the Special Investigations provided a rationale for the conclusion and addressed conflicting evidence. This is not consistent with my findings.

Current recommendations:
1. Revise summary statements to support the determinations made, citing specific information and addressing conflicting information.
2. Identify relevant conflicting evidence and document clearly attempts to reconcile conflicting evidence.</td>
</tr>
<tr>
<td>I.1.b.iv.
4</td>
<td>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent.</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Consider a different review process that uses an Incident Review Committee composed of a variety of staff with various expertise and</td>
</tr>
</table>

	Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	job titles. **Findings:** The decision was made to continue the use of the present review system. As reported earlier, the reviews of the sampled investigations were substantially more thorough than previously. They identified programmatic corrective actions and deficiencies in the investigations themselves. **Recommendation 2, March 2007:** If the decision is to keep the present process, the reviews would be enhanced by the identification of four to five critical elements that the reviewers must address in their review. **Findings:** A new review form has been designed and will soon be implemented that assigns specific areas of review to each of the reviewers to help focus the reviews and ensure that no elements are overlooked. **Current recommendation**: Evaluate the effectiveness of the new review form once in use to ensure it is meeting its objectives.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue current practice of routing all investigations with their review forms to HR. **Findings:** Investigations are still routed through HR. The HR Director reviews the investigation and the reviews done by others in leadership positions and composes a memo to the program identifying each corrective

		measure that must be taken and assigns a date by which the program must respond back. The memos in the investigation files were very well done. **Recommendation 2, March 2007:** Refine the Human Resource form to include, in addition to the information currently provided, the incident number, the type of recommendation using a simple coding system, (e.g. T=training, CS=change of shift, AD=review Administrative Directive), the date the notice was sent to the program. **Findings:** See above. The information regarding needed corrective actions provided to the program at the close of the incident review process prepared by HR is complete and comprehensive and the response back from the unit is tracked. **Other findings:** Tracking the disciplinary measures for eight staff members yielded the following results: One staff member determined to have abused an individual was placed on administrative leave and resigned before she could be terminated. Two staff members who failed to properly document their monitoring of an individual in restraint received Letters of Instruction. The counseling memo for two staff members due to HR by 8/20/07 had not yet been completed on 8/30/07. The counseling memo for a third staff member was also late. The counseling for a fourth staff member due on the same date had been completed. An adverse action was taken against one staff member related to two incidents. **Compliance:** Partial.

		Current recommendations: 1. Take measures to ensure that units respond to the memos from HR regarding disciplinary and programmatic corrective actions in a timely manner. 2. Continue current practice of HR providing the units with complete information about which actions need to be taken and requesting evidence of completion.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Determine what reports will be useful to the hospital on a monthly and quarterly basis, to whom they should be sent, and how they will be reviewed. **Findings:** MSH has begun producing periodic reports on the use of restraint and seclusion, Stat and PRN medication, and aggression. These reports are provided to the Performance Improvement Committee. **Recommendation 2, March 2007:** Use the capacity of the incident database to produce these reports and accompany them with narrative analyses. **Findings:** According to Standards Compliance and as recorded in the minutes, the reports cited above are shared with the Performance Improvement Committee along with a verbal analysis presentation.

		Recommendation 3, March 2007: Review the reports, including the report for 2006 referenced above, to identify areas that need further study or recommendations for preventative measures. **Findings:** Work in this area is beginning. Performance Improvement Committee minutes have yet to record the discussion of the reports and recommended actions, if any. **Current recommendation**: Write Performance Improvement Committee minutes to reflect discussion of the reports and actions recommended.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Start producing reports related to staff accused in allegations of abuse and neglect and circulate as appropriate. **Findings:** This recommendation has been implemented. **Recommendation 2, March 2007:** Allow investigators access to "staff as subject" information in the incident database. **Findings:** Special Investigators can access the incident history of any staff member through Standards Compliance. **Current recommendation**: Continue to review the incident and disciplinary history of staff and

		the incident history of individuals during investigations and document the results of this review in the investigation report.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Develop a report that is produced and reviewed regularly that identifies repeat aggressors and repeat victims and other relevant information, such as described above. **Findings:** This report is not yet produced regularly. However, a report has been produced each month since March that identifies by name the individuals who have been the aggressor in more than two incidents and the individuals who have been the victim of two or more physically aggressive acts by peers. Review of these reports indicates that two individuals, DH and ML, have been aggressors multiple times in four of the five months studied (March-July). These two individuals account for nearly 60% of the incidents in these reports. A review of the reports on individuals who have been victims of multiple incidents of peer physical aggression indicates that one individual (WH) appears most often--in three of the five months studied. **Recommendation 2, March 2007:** Ensure distribution of the report and a response from the WRPTs. **Findings:** There was no documentation presented that indicates that these patterns were identified and addressed.

		Recommendation 3, March 2007: Review the coding of the role of individuals in self-harm incidents and clarify whether the individual should be coded the aggressor or the victim. **Findings:** This remains a problem. Individuals who have attempted suicide are variously coded on the SIR as aggressor, involved, or very occasionally, victim. **Current recommendations**: 1. Document the analysis of the reports produced and the actions taken in response. 2. Standardize the correct coding for individuals who attempt suicide.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Start producing a report on the location of incidents on a regular basis, accompanied by analysis of the data, documentation of the results of the review of this information, and any recommendations stemming from the review. **Findings:** MSH began in July 2007 to produce a report on the location of incidents based on SIR data. The report covering March 1, 2007 through August 24, 2007 indicates that the hallway, day hall and "other area" account for the location of two-thirds of the allegations of abuse/neglect. The day hall and hallway are likewise the location of 61% of the incidents of peer-to-peer aggression. The multiple aggressor report (cited above) also indicates that the hallway was the scene of more of these incidents than any other

		location. Similarly, the multiple victim report indicates that hallways were the location most often for the incidents referenced in that report. **Current recommendation**: Document the analysis of these reports and the recommendations that result from the Performance Improvement Committee's discussion of these reports.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Produce, analyze and review reports on day and time of incidents on a regular basis. **Findings:** A report on the time of day incidents occurred in the period March 1, 2007 through August 24, 2007 indicates that nearly 40% of the incidents occurred in the four hour period 2:00-6:00 PM **Current recommendation**: Document the discussion of this and like reports and any recommendations identified during the review by the Performance Improvement Committee.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue work on this form and implement it across hospitals once it is approved. **Findings:** The Headquarters Reportable Briefing form has been revised to

		identify the factors contributing to serious incidents. It has been agreed that the thoughtful completion of this form will fulfill the intent of this portion of the Enhancement Plan. **Current recommendation**: Review the Headquarters Reportable Briefing forms to ensure that they reflect thoughtful consideration of the contributing factors.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, March 2007:** Write a complete and concise summary of findings supporting the determination that addresses the elements of the abuse allegation and whether the findings meet the preponderance standard of evidence. **Findings:** See I.1.b.iv.3(viii). **Current recommendation**: Revise summary statements to support the determinations made, citing specific information and addressing conflicting information.
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff	**Current findings on previous recommendation:** **Recommendation, March 2007:** Add a check box on the face sheet of the investigation to indicate that the staff member was reassigned to non-individual contact duty and include this question on the monitoring tool. This will facilitate the hospital's own self-assessment of this portion of the Enhancement Plan. **Findings:** The investigation reports clearly indicate that a staff member has been removed from the unit. The memo from HR to the unit clearly

	person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	directs the unit to return the staff member to work, etc. In addition, the hospital has initiated an Incident Management Review process composed of the Executive Director, Clinical and Hospital Administrators, Chief of Police, Human Resources Director, Medical Director and the Coordinator of Nursing Services that determines whether a staff member can be put back to work, under supervision, pending the outcome of an investigation. These activities meet the intent of this section of the Enhancement Plan. **Compliance:** Partial. While the necessary systems are operational to remove staff from the units when there is a credible allegation of abuse, neglect or exploitation, the hospital cannot be determined to be in substantial compliance until the investigations are more timely and the determinations more adequately defended. **Current recommendation:** Continue current practices related to the removal of staff members when credible allegations of abuse, neglect and exploitation are made.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. M. Nunley, Standards Compliance Director 2. M. McNeil, Standards Compliance 3. C. Lusch, Clinical Administrator Reviewed: 1. Aggregate key indicator data 2. Multiple aggressor and multiple victim reports 3. Weekly trigger meeting minutes 4. AD 3133.1 Trigger Response 5. Report of WRT Responses to Activated Triggers
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue to refine the data collection systems to ensure the data is useful, accurate and not duplicative. **Findings:** There is evidence that problems in accuracy of some key indicator data persist. For example, the Mortality Review Committee minutes indicate that one individual (JC) died on April 23, 2007. The key indicator data cites no deaths in April. The minutes also note two deaths in June (AW and FG), but the key indicator data shows only one death in June.

		Recommendation 2, March 2007: Redefine sexual incidents to, at a minimum, distinguish between coercive or exploitive sexual activity, sexual activity between a staff member and an individual in care and consensual adult sexual activity. Redefine rape. **Findings:** The problems with the SIR definitions related to sexual activity have been satisfactorily addressed in the revised definitions that have been adopted. **Recommendation 3, March 2007:** Ensure the data makes sense, perhaps by having someone outside of the discipline/program review the data. **Findings:** See the findings related to data presentation in this entire report. **Recommendation 4, March 2007:** Begin testing for inter-rater reliability. **Findings:** It appears that hospitals may not be collecting consistent information for some key indicators. **Other findings:** DMH acknowledges that all hospitals are not adhering to the business rules agreed upon for collecting key indicator data. For example, some hospitals are only counting abuse/neglect allegations if there is an injury. MSH is counting all abuse and neglect allegations.

		Current recommendation: Revisit and clarify the business rules for counting key indicators so that consistent information is collected across all hospitals.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Continue to implement AD 3133.1. **Findings:** The hospital continues to make progress in tracking trigger data and responses from the WRPTs. As noted, consistency in data collection among the hospitals needs attention. **Current recommendation**: Revisit and clarify the business rules for counting key indicators so that consistent information is collected across all hospitals.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** In addition to identifying individuals who are high risk because of their aggressive behavior, identify those who are at high risk because they are repeat victims. **Findings:** The implementation of this recommendation began in March 2007. A monthly report is produced that identifies by name the individuals who have been victims in that month of more than two physically aggressive acts by peers. Review of those reports indicates that one individual appears in three of the five monthly reports.

		Recommendation 2, March 2007: Begin tracking these individuals to determine whether interventions are effective and report this information in the appropriate forum. **Findings:** Presently the hospital does not review the effectiveness of interventions. **Other findings:** The hospital has concentrated its efforts on producing pattern and trend reports related to the use of restraint and seclusion, PRN and Stat medications, and multiple aggressor and victim data, as well as the reports from incident data related to location and time of day of incidents. **Current recommendation**: Expand the type of reports produced and document the hospital's discussion of the reports and any measures recommended in response.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Implement AD 3133.1 and track the responses from the WRPTs for compliance. **Findings:** A report for the month of July for persons who reached triggers related to aggression (self or others) and restraint/seclusion indicates

		that there was no response back from the WRPT for 13 of 16 individuals (81%). **Other findings:** The hospital has produced a report covering the period March 1 through July 31, 2007 that describes the frequency with which specific actions were taken by WRPTs in response to specific triggers. For example, the most frequently used intervention for individuals who reached the aggression to peer trigger was change in medication (35% of the interventions reported). A consultation with the PBS team or implementation of a PBS plan was undertaken, according to the report cited above, a total of 12 times for individuals who reached the aggression to peer, aggression to self, non-adherence to WRP, 1:1 observation, PRN use and restraint key indicators during the five-month period studied. **Current recommendations**: 1. Discuss this report in the appropriate forum to determine if the results are as expected. 2. Take appropriate measures to get responses back from WRPTs to ensure attention is being paid to these high-risk individuals
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Implement AD 3133.1 and track the responses from the WRPTs for compliance. **Findings:** See I.2.b.i above.

		Current recommendations: 1. Take appropriate measures to get responses back from WRPTs to ensure attention is being paid to these high-risk individuals. 2. Consider at what point failure to consider and/or implement some action constitutes neglect.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, March 2007:** Implement AD 3133.1. **Findings:** MSH has a weekly trigger meeting where the treatment of individuals who have reached behavioral triggers are discussed. **Other findings:** The trigger meeting minutes for 7/31/07 state that follow-up information on 10 individuals was requested and should be provided at the next meeting on 8/7/07. The minutes of the 8/7 and 8/14 meetings contain follow-up information on seven of the 10 individuals. (I extended the review to the 8/14 meeting because some delays are to be expected.) **Current recommendation**: Track the discussion of individuals in the weekly trigger meeting and ensure that all discussions come to closure in a timely manner.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, March 2007:** Implement AD 3133.1.

		Findings: See findings in I.2.b.iii. **Current recommendation**: Improve the response from units back to the Standards Compliance and to the weekly trigger meeting.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Select a sample of the responses from WRPTs and ensure that the actions described have been implemented by the date indicated. **Recommendation 2, March 2007:** Produce a report on these findings. **Findings:** These recommendations have not been implemented. MSH has not initiated a study of a sample of individuals to determine if responses to triggers have in fact been implemented. **Current recommendations**: 1. Select a sample of the responses from WRPTs and ensure that the actions described have been implemented by the date indicated. 2. Produce a report of these findings and share it with the Performance Improvement Committee and the sampled units.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, March 2007:** In response to the findings in this report related to monitoring tools, identify those that are helpful and eliminate those that are unnecessary and/or ineffective.

		Findings: Please see other sections of this report for findings related to monitoring tools. **Compliance:** Partial. **Current recommendation**: See recommendations throughout this report that address the hospital's self-assessment process.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. H. Mears, Chief of Police 2. D. Hill, Health and Safety 3. L. Maldonado, Assistant Hospital Administrator 4. W. Coleman, Health and Safety Officer 5. A. Hendrick, Coordinator of Nursing Services 6. A. Sobolewska, Nursing Performance Improvement Coordinator 7. K. Layman, Treatment Enhancement Coordinator Reviewed: 1. Semi-annual environmental audits of six units. 2. Log of semi-annual audits that includes date of unit response 3. Incontinence data 4. Nursing Policy re: Bowel and Bladder Incontinence Management 5. WRPs of eight individuals with problem of incontinence 6. Log of environmental modifications related to safety that provides current status of projects 7. AD 3412 "Sexuality and Safety of Individuals" Toured: 1. Six units—414, 416,407, 404, 412, 413
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Discuss the documentation system described above for daily inspections of the units with nursing personnel and implement it, if nursing finds it helpful.

		Findings: Daily environmental reviews are documented. Walk-throughs occur at change of shift. **Recommendation 2, March 2007:** Continue current practices in addressing suicide and self-harm risks and in care of the environment in general. **Findings:** The hospital has several major suicide and self-harm hazard prevention projects underway. These include the replacement of spring beds with pan beds, the encasing of the strobe lights, modifications to the fire extinguisher boxes, replacement of shower grab bars, replacement of glass windows with plexiglass, and the installation of sloped showerheads. A budget proposal has been submitted for changing the bathroom partitions. **Recommendation 3, March 2007:** Include in the list of work to be completed on suicide hazards the enclosure of bathroom sink plumbing. **Findings:** The undersink plumbing has not been enclosed in the units toured, but it has been added to the prioritized list of work related to reducing suicide hazards. **Recommendation 4, March 2007:** Include on all inspection instruments (daily through semiannually) a review of the appearance of the individuals in care (cleanliness, grooming, clothing). **Findings:** This recommendation had not been implemented in the inspection

		reports reviewed. The inspection reports address the supply of personal hygiene products available, but not the appearance of the individuals. The hospital documentation indicates that a section for comments on appearance has or will be added to the inspections. **Recommendation 5, March 2007:** Ensure that ADL issues are addressed in the WRPs of those individuals who need support in grooming, etc. **Findings:** The WRP for one individual whose bedroom (which he shares with several others) had a strong urine odor and whose roommate reports he urinates in the wardrobe contained no reference to the problem. **Recommendation 6, March 2007:** Review the semi-annual inspection reports for completeness. **Findings:** A review of the semi-annual inspection reports for six units revealed that two units (405 and 412) had not responded at all with work order dates or dates deficiencies were corrected, one unit had addressed all issues noted, two had addressed most issues, and one had addressed a few of the issues noted in its inspection. **Recommendation 7, March 2007:** Continue the use of the Inspection Tracking Grid to ensure timely reports to and response from the programs/areas inspected. **Findings:** A review of the Inspection Tracking Grid reveals that of the 16 living units inspected from 4/5/07 through 7/19/07, 14 (87.5%) had responded back to the inspection team with the dates work orders were submitted or the date the deficiency was corrected.

		Other Findings: The bathrooms in nearly all of the units visited were dirty and unattended. Examples of problematic conditions include: • Three stalls had no toilet paper on Unit 411 • Three stalls had no toilet paper on Unit 416 • Two stalls had no toilet paper on Unit 412 • Racial slurs (graffiti) on bathroom wall in Unit 412 • Toilets were dirty on Unit 401 • One toilet was plugged and the shower was moldy in Unit 407 • One partition door was off the hinges, two stalls had no doors, two stalls had no toilet paper and there was a strong urine odor in a bathroom on Unit 414. These conditions suggest that daily and end-of-shift inspections are not sufficiently rigorous. It further suggests that bathroom etiquette should be identified as an ADL focus for some number of individuals. Dirty bathrooms were also discussed during the Individual Council meeting as a continuing problem. **Compliance:** Partial. **Current recommendations:** 1. Take appropriate action when a unit does not respond to an inspection report to ensure that issues have been addressed. 2. Review environmental conditions more critically during daily and end-of shift inspections. 3. Direct attention in the WRP to the needs of individuals who compromise their own and the health of others by unsanitary bathroom habits.

I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Continue current practice. **Findings:** No areas of the hospital visited were uncomfortably warm, with the exception of the nurses' station on one unit. **Recommendation 2, March 2007:** Ensure that each unit has a thermometer that measures water temperature, as well as one that measures air temperature. **Findings:** The units toured were equipped with a thermometer that measured both air and water temperature. **Other findings:** It was very warm outside on the two days I toured units; the temperature in all units visited was mildly warm but not unreasonable. The water temperature in the bathroom sinks tested was below the "alarm" temperature of 110 degrees. Hospital data indicates that it was able to correct 83% of the complaints from units related to temperature. Plant Operations explained that in some situations, fixing the temperature on one side of the building causes problems on the other side. **Compliance:** Substantial, based on a limited sample of units.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>I.3.c</td><td>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</td><td>Current findings on previous recommendations:

Recommendation 1, March 2007:
Revise the text of the Nursing Policy and Procedure entitled "Bowel and Bladder Incontinence Management" to eliminate the language that limits the inclusion of goals and interventions into the WRP to only those individuals whose incontinence is irreversible.

Findings:
The Nursing Policy has been revised as described.

Recommendation 2, March 2007:
Adopt and implement the revised policy/procedure.

Findings:
Implementation of the policy is problematic as described below, despite training having been provided.

Other findings:
A MSH nursing audit of 62 individuals identified with the problem of incontinence determined that in only 12 (19%) instances was the problem addressed in Focus 6 in the individual's WRP. The review found similar low compliance with the policy requirements for completion of the incontinence assessment form and for completion of the bowel/bladder worksheet.

My review of eight individuals identified as having an incontinence problem showed similar poor compliance with the policy.

<table>
<tr><td>Indiv. initials</td><td>Incontinence listed as dx</td><td>Addressed in WRP</td></tr>
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		<table><tr><td>EM</td><td>No</td><td>No</td></tr><tr><td>GA</td><td>Yes</td><td>No</td></tr><tr><td>VF</td><td>No</td><td>Yes</td></tr><tr><td>ST</td><td>No</td><td>No</td></tr><tr><td>TR</td><td>Yes</td><td>Yes</td></tr><tr><td>WH</td><td>No</td><td>No</td></tr><tr><td>JP</td><td>Yes</td><td>Yes</td></tr><tr><td>SR</td><td>No</td><td>No</td></tr></table> **Compliance:** Partial. **Current recommendations**: 1. Implement the Nursing Policy as revised in June 2007 and continue to monitor for compliance. 2. Expand the monitoring form to move it beyond a paper review to include an observation of the individual and interview when possible to determine if individual is clean, dry and odor-free and whether he/she is cooperating in addressing the incontinence problem.
I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Current findings on previous recommendations:** **Recommendation 1, March 2007:** Write a set of sexuality guidelines that are easy to understand. This can be a separate document or a revision of the AD 3412. The document produced should straightforwardly address consensual sexual activity between adults. **Findings:** AD 3412 has been revised and permits private, protected sexual activity between consenting individuals. It specifically addresses those circumstances when staff intervention is required.

		Recommendation 2, March 2007: Consider simplifying the definition of "staff intervention" in the present policy to read, "Action by staff that interrupts the natural sequence of events that would have otherwise occurred." **Findings:** This language change has been made in the revised policy. **Recommendation 3, March 2007:** Consider asking the Individual Council or a subcommittee of the Council for assistance in drafting the guidelines. **Findings:** Members of the Individual Council were included as members of the Individual Safety Committee that reviewed the Sexuality and Safety Policy. The revised finished policy will be shared with the Individual Council soon. **Other findings:** Since MSH provides inpatient services to adolescents (minors), AD 3412 (Sexuality and Safety) should be closely reviewed to ensure that those portions of the policy that apply only to adults clearly state this. **Compliance:** Partial. **Current recommendation**: Review AD 3412 and clearly identify those portions that apply only to adults.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to	**Current findings on previous recommendation:**

	provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Recommendation, March 2007:** Develop a method whereby the hospital is assured that everyone who is not a clinician but is working in the Mall has completed the Basic Group Leadership course and the other prerequisites. **Findings:** The Basic Group Leadership course was attended by 26 non-clinical staff members in June and August 2007. (Several non-clinical staff had attended the class in 2006.) There is no documentation that all staff leading Mall groups have attended. **Other findings:** A course in Mental Health 101 will be added shortly to the required courses for non-clinical staff participating in Mall groups. **Compliance:** Partial. **Current recommendation**: Identify all Mall providers and check that list against the required course attendance sheets to ensure that all have completed the required courses.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. The Individual Council is active in providing counsel and perspective to the hospital administrators about issues related to safety and quality of life. 2. The Safety Team, which includes Council members, has rank-ordered safety factors and will be making recommendations for implementation. 3. Hospital administrators are responsive to the input and concerns of the Individual Council.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. K. Layman, Treatment Enhancement Coordinator 2. Five individuals during unit tours or at close of Individual Council meeting <u>Reviewed</u>: 1. Individual Council First Amendment and Due Process survey results 2. Individual Council meeting minutes for March through July 2007 3. Charter Proposal and minutes of the Safety Team <u>Observed</u>: 1. Individual Council Meeting
J		**Current findings on previous recommendation:** **Recommendation 1, March 2007:** Continue current practice.

		Recommendation 2, March 2007: Pursue those initiatives that are still pending. **Findings:** The Individual Council continues to address safety issues, such as sexually transmitted diseases, antibiotic-resistant infections, and initiatives to reduce violence on the units. **Recommendation 3, March 2007:** Use the incident data and conversations to identify individuals who are repeatedly involved in incidents. **Findings:** As indicated earlier, the hospital has identified those individuals who have been involved in multiple incidents as aggressor or victim. **Recommendation 4, March 2007:** Consider environmental factors that may be contributing to incidents. **Findings:** The Safety Team, with individuals as active members, has identified and prioritized safety issues. **Other findings:** A review of the results of the First Amendment and Due Process survey compiled by MSH in July 2007 reveals that 72% of the 167 respondents indicated that they felt safe. Reasons for not feeling safe focused on peer-to-peer aggression. Questions that elicited a positive response by 80% or more of the respondents included the following: • Access to personal hygiene supplies? • Treated with respect by staff?

		• Encouraged to participate in identifying needs, goals and treatment options? • Taught the purpose of your treatment rehabilitation and enrichment services? • Taught about medications—the expected results, common and serious side effects? • Able to communicate freely with family, attorney, advocate? • Able to report abuse/neglect if you see it? 31% of the individual respondents reported that they had been placed in restraint or seclusion. 29% reported that they were restrained or secluded as punishment. Review of the Individual Council meeting minutes indicates that the hospital has developed a form that an individual signs to request a copy of his/her WRP. There is some suggestion that individuals have been denied copies of their WRPs. This needs clarification. During the Individual Council meeting that I attended, two issues were discussed extensively: violence on the units and the lack of resources available to CONREP. Individuals discussed the problems they encounter when their peers attack them. Not only do they need to worry about being hurt, but they need to worry lest any attempt to defend themselves be misinterpreted as aggression and delay their meeting their discharge criteria. Individuals expressed concern and exasperation because CONREP has such limited resources that they feel trapped at the hospital well after they have met discharge criteria, but yet cannot be released to outpatient treatment. Individuals described their situation as being "warehoused." **Compliance:** Partial.

		Current recommendations: 1. Continue current practice of soliciting input from the Individual Council on substantive matters. 2. Continue the work of the Safety Team. 3. Clarify whether there is a problem with individuals being denied copies of their WRPs and take appropriate action. 4. DMH should exercise any influence it has in increasing the capacity of CONREP.